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No. 19

In the Supreme Court of the United States

OCTOBER TERM, 1951

THE UNITED STATES OF AMERICA, APPELLANT

v.

OREGON STATE MEDICAL SOCIETY ET AL.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF OREGON

BRIEF FOR THE UNITED STATES

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OPINION BELOW

The opinion of the district court (R. 2005) is reported in 95 F. Supp. 103.

JURISDICTION

The judgment of the district court was entered on November 3, 1950 (R. 2031). A petition for appeal was filed on December 22, 1950 and was allowed the same day.[1] On April 9, 1950, this

[1] These and other appeal papers have been filed with this Court but appear, through inadvertence, not to have been included in the printed record. The parties have stipulated, however, that they may refer "to any portion of the record on appeal in this case on file in the office of the Clerk whether or not said portion is included in the printed record on appeal" (R. 7537).

Court postponed consideration of its jurisdiction and of a motion by appellees to dismiss or affirm until a hearing on the merits (R. 7539). The jurisdiction of this Court is conferred by Section 2 of the Expediting Act of February 11, 1903 (32 Stat. 823), as amended by Section 17 of the Act of June 25, 1948, 62 Stat. 869, 15 U. S. C. Supp. IV, 29.

QUESTIONS PRESENTED

1. Whether the findings of the court below that appellees have not combined and conspired to restrain or attempted to monopolize the prepaid medical care business in Oregon are clearly erroneous and must be set aside.

2. Whether the restraints which were the subject of the combination and conspiracy can be justified as reasonable on the ground that they were imposed in an effort to maintain asserted professional standards of medical ethics or otherwise.

3. Whether the business of supplying prepaid medical care constitutes "trade" or "commerce" within the meaning of the Sherman Act.

4. Whether the restraint and monopolization charged against appellees involved or affected interstate commerce.

STATUTE INVOLVED

The Act of July 2, 1890, 26 Stat. 209 (15 U. S. C. 1, *et seq.*), known as the Sherman Act, provides in part as follows:

> SEC. 1 [as amended by the Act of August 17, 1937, 50 Stat. 693]. Every contract,

combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal; * * *

SEC. 2. Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a misdemeanor * * *.

SEC. 4 [as amended by the Act of March 3, 1911, Sec. 291, 36 Stat. 1167]. The several district courts of the United States are hereby invested with jurisdiction to prevent and restrain violations of this act; and it shall be the duty of the several district attorneys of the United States, in their respective districts, under the direction of the Attorney General, to institute proceedings in equity to prevent and restrain such violations. * * *

STATEMENT

A. THE NATURE OF THE CASE AND THE DECISION OF THE DISTRICT COURT

1. THE PLEADINGS

This is a civil suit instituted by the United States in October 1948 (R. 1), under Section 4 of the Sherman Act, to enjoin alleged violations of Sections 1 and 2 of that Act. The complaint, as supplemented by more definite statements (R. 12, 70, 75, 77, 79, 81), charged that the Ore-

gon State Medical Society, eight county medical societies, a corporation selling medical society approved prepaid medical care, and eight individual doctors in Oregon had, since January 1, 1936, conspired and combined to restrain and monopolize the business of selling and furnishing prepaid medical care in Oregon and elsewhere.

The charges in the complaint may be briefly summarized. The appellees engaged in a continuing conspiracy and attempt to restrain and monopolize the prepaid medical business in Oregon, and to limit the scope of medical care provided under prepaid medical care plans. The appellees conspired, with respect to prepaid medical care plans not sponsored by them, (1) to prevent, eliminate, hinder, and obstruct such plans; (2) to restrain residents of Oregon and other States from entering into or continuing under such plans; (3) to prevent doctors from cooperating with them; (4) to restrict the use of hospital facilities by doctors cooperating with them; and (5) to prevent the use of Oregon hospital facilities by doctors and patients associated with such organizations.

The conspiracy and resulting restraints of trade were effectuated by the following means, *inter alia:* appellees hindered and obstructed prepaid medical care organizations in their attempts to procure and retain qualified doctors. They expelled, threatened and incited expulsion, and caused the resignation from medical societies of

doctors who cooperated in prepaid medical care plans not approved by them. The appellees formed and promoted their own plans to drive out and hinder commercial plans. They caused doctors to refuse to treat patients covered by plans not approved by them unless the patients paid cash and to refuse to give such patients itemized statements to enable them to obtain reimbursement. Appellees agreed among themselves not to compete with each other for prepaid medical care business.

As a result of the foregoing, prepaid medical care organizations not sponsored by appellees were prevented from or hindered in entering into or expanding their business, some of such organizations were driven out of business, members of the public and business concerns were deprived of a fair opportunity to obtain prepaid medical care in an unrestrained market, and doctors were denied the opportunity to practice medicine on terms of their own choosing.

Appellees, in their answer, admitted the lack of competition among medical society sponsored plans, and denied all of the Government's other charges (R. 83–87).

2. THE PROCEEDINGS BELOW

Trial of the case before Judge Claude McColloch began in October 1949 and ended in February 1950. The Government's proof dealt with two aspects of the alleged conspiracy: (1) the

restraints on the business of the privately owned prepaid medical care organizations, particularly the so-called hospital associations, and (2) the restriction of competition and limitation of coverage among medical society approved plans. The evidence introduced by the Government consisted to a large extent of uncontroverted documentary material. Much of this was taken from appellees' own files, consisting of minutes, committee reports, written agreements and correspondence, as well as their publications. There was introduced in evidence a stipulation as to certain facts (Gov. Ex. 1751, R. 5333). There was also introduced in evidence a number of contemporary letters written by doctors, employers, employees and others relating to the events in the conspiracy.

The Government put 45 witnesses on the stand. Of these, 14 were executives of business concerns; 11 were officers of labor unions; 9 were executives or employees of prepaid medical care organizations; 11 were Oregon doctors and nurses; 1 was a housewife; 1 was a hospital executive; 1 was a policeman; 1 was an executive of a fraternal organization; and 1 was a member of a cooperative organization. These witnesses testified to the fact of boycott as well as to its effect. Some of them testified to other aspects of the conspiracy. In very large part, their testimony not only went uncontradicted by appellees but was supported by documentary proof.

The appellees' case was largely testimonial. Appellees' witnesses consisted of members of the appellee medical societies and officers of appellee Oregon Physicians Service (hereinafter referred to as "OPS"). Their case comprised denials that they had conspired as charged, and avowals that their activities had been motivated solely by a desire to maintain the ethical standards of the medical profession. A number of doctors testified that they had refused to deal with the hospital associations because of dislike for their practices, and that such decisions were arrived at independently and not as the result of medical society policy or pressure.[2] A few of appellees' doctor witnesses testified that they had always dealt with the hospital associations. Appellees also introduced evidence as to the alleged unethical practices of the hospital associations.[3]

[2] There were only three private hospital associations which operated both before and after 1939: National Hospital Association, Industrial Hospital Association, and Prudential Hospital Associations. Although most of appellees' witnesses criticized one or two of these associations, only one referred to Prudential and then obliquely. Appellees' counsel told the court during pretrial proceedings that *two* of them conducted their affairs at an early period contrary to the Code of Ethics (R. 233). No witness attacked the Weston and Pumphrey companies, two smaller prepaid medical care plans that ceased such business in 1940.

[3] The Government maintained such evidence was irrelevant. See *American Medical Association* v. *United States*, 130 F. 2d 233, 248–249 (C. A. D. C.), affirmed on limited grant of certiorari, 317 U. S. 519. In addition, in rebuttal, it put into evidence many documents showing similar practices by prepaid medical care organizations sponsored by appellees.

On September 28, 1950, following the filing of an extensive trial brief by the Government, but before the date fixed for filing of appellees' brief, Judge McColloch filed a document entitled "Opinion, Findings and Notes" holding that the Government had failed to prove any of its charges (R. 2005). The document is a summary statement of the court's conclusions on the law and facts, together with notes of what appear to be random reactions of the judge during the course of the trial.[4] Typical of these is Note 12 (R. 2011):

> *The Age of the Common Man*
>
> In a measure, this case is an attack on the professions. Everything critical of the doctors that has been said in the case could be said of the legal profession.
>
> The World Revolution that we hear about allows no place for the professions. All that is principle, dignity, the efforts of the ages to create an aristocracy of intellect—these are to be destroyed in the interest of "the common man."
>
> He will be "common", indeed, without professions in the society which he is to rule.[5]

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[4] These notes, however, were given formal status by the trial judge, who stated (R. 2016):

> The foregoing findings and notes may be deemed and treated as Findings of Fact on factual matters and as Conclusions of Law on legal questions—to be supplemented by formal Findings and Conclusions if counsel deem it necessary or appropriate to submit further Findings and/or Conclusions for consideration.

[5] See also Note 14 (R. 2012):

The district court subsequently filed detailed findings of fact and conclusions of law which, with one exception, were identical with those proposed by appellees (R. 7508).

B. THE EVIDENCE

For the convenience of the Court in weighing the Government's challenge to certain of the findings, there will be included in the following statement of the evidence a recital of the basic findings specifically challenged, together with the evidence believed to refute them. In each case it will also be stated whether there is any evidence tending to support the findings. In the few instances where there appears to be such evidence, we shall en-

Socialized Medicine

> may overtake them but the doctors claim the right to save the profession from socialism. That is what this case is about, according to the doctors' viewpoint. As to this defense it must be conceded that the purpose with which action is taken is of prime importance under the Sherman Act.

and Note 17 (R. 2013):

The Legal Profession Next

> The trend and drift towards Socialized Medicine should be all the lawyer needs to recognize that Socialized Law is but the next step for those dedicated to the socialized-police state * * *
>
> The socialization of the law, if lawyers permit it to come about, will ultimately contribute more to the destruction of Democracy than any other thing that can happen. It can happen here.
>
> (Quoted from Oregon State Bar Bulletin, Alexander B. Brown, editor, August 1950.)

deavor to summarize it fairly. Other findings challenged by the Government will be discussed in that portion of the argument dealing with the evidentiary basis for the findings.[6]

Certain of the challenged findings are general in character and must be considered in the light of the entire evidence. Thus, the trial judge found that there was no conspiracy (Fdgs. 20, 21, R. 2021); that there was no motive to restrain or monopolize (Fdg. 37, R. 2025–6); and that no monopoly or unreasonable restraint was achieved (Fdgs. 37, 43, R. 2025–6, 2026–7). The trial judge also found that if there was a conspiracy prior to 1941, it ended in that year and in the period 1941 to 1945 (Fdgs. 38, 39, R. 2026). Because of these findings of abandonment, we have set forth with particularity the dates of acts which are alleged to be in furtherance of the conspiracy.

1. THE APPELLEES AND THEIR RELATIONSHIP TO EACH OTHER

The appellees are the Oregon State Medical Society (hereinafter referred to as the "State Society"); 8 county medical societies, Clackamas County Medical Society, Clatsop County Medical Society, Columbia County Medical Society, Douglas County Medical Society, Jackson County Medical Society, Lane County Medical Society,

[6] The salient facts relating to interstate commerce are set forth in the section of the argument dealing with that aspect of the case. See pp. 182–193, *infra*.

Marion-Polk Counties Medical Society and Multnomah County Medical Society; Oregon Physicians Service, an Oregon corporation engaged in the prepaid medical care business; and 8 individuals, Doctors Baum, Besson, Brennan, Fitzgibbon, Hunt, Leitch, Martzloff, and McLean (Fdgs. 1–11, R. 2017–19).

a. Oregon State Medical Society

The State Society is a constituent association of the American Medical Association (Gov. Ex. 1751, R. 5333). It is governed by a House of Delegates, composed of delegates elected by the component local medical societies on the basis of one delegate for each 25 members, and certain designated officials of the society (Gov. Exs. 4, R. 2063–4, 2073; 1751, R. 5337). The House of Delegates meets once or twice a year (Gov. Exs. 4, R. 2064, 2074; 666, R. 3721); when it is not in session the governing body is the Council (Gov. Exs. 4, R. 2064; 1751, R. 5337). The Council consists of 10 councilors, representing the 7 councilor districts into which the state is divided, the officers of the society, the retiring president, and society members who are officers of, or delegates to, the American Medical Association (Gov. Ex. 4, R. 2064, 2078). The Council acts as a Board of Censors for the society and has charge of all disciplinary matters (Gov. Ex. 4, R. 2064, 2075, 2086–9). The State Society has a number of standing committees (Gov. Ex. 4, R. 2080–81).

In 1948 and 1949, approximately 75 percent of all doctors practicing in Oregon were members of the State Society (Fdg. 50, R. 2029; Gov. Exs. 1751, R. 5339; 1859, R. 284, 468).

Oregon State Medical Society publishes jointly with the State Medical Societies of Idaho and Washington a monthly medical magazine called Northwest Medicine, which is described on its masthead as the journal of the three societies (Gov. Exs. 278, R. 2855; 279, R. 2858; 280, R. 2889; 1751, R. 5346). Each issue of the magazine contains, in addition to articles of general interest, separate state sections including matters of particular interest to individual states (Gov. Exs. 339, R. 3134; 900, R. 4279).[7] The Oregon state section frequently contains official notices, announcements, and proceedings of the State Society (Gov. Ex. 900, R. 4279). The doctor has been urged to read the state sections to "be posted on activities and matters of importance concerning his own organization" (Gov. Ex. 340, R. 3137; see Gov. Ex. 339, R. 3134), and in 1940, the Council recommended that the secretaries of county societies read excerpts from the Oregon section as a method of "disseminating information concerning the activities of the Society"

[7] Since 1946, the Oregon section of Northwest Medicine has carried a legend that articles appearing therein do not necessarily represent the opinions of the Oregon State Society, and the State Society has required that articles expressing personal opinions be signed (Gov. Exs. 287, R. 2946; 288, R. 2962; 367, R. 3225–6; *cf.* R. 1553).

(Gov. Exs. 344, R. 3170; 350, R. 3192–3). State Society members received a subscription to the magazine upon payment of dues (Gov. Ex. 1862, R. 125, 469).

Northwest Medicine is controlled by a board of 9 trustees, 3 of whom are designated by each state medical society (Gov. Exs. 900, R. 4279; 901, R. 4280).[8] During the period of the alleged conspiracy, many representatives of the State Society have been officially connected with Northwest Medicine (Gov. Ex. 1862, R. 125, 469)[9] and the secretary of each State Society is *ex officio* an assistant editor of the magazine (Gov. Ex. 901, R. 4280). The State Society has closely supervised the Oregon section of the magazine.[10]

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[8] Appellee Martzloff, one of the trustees of Northwest Medicine, testified that the trustees never have exercised any editorial control over the magazine (R. 1444). Appellee McLean, likewise a trustee, stated that the trustees had not endeavored to exercise any control over the Oregon editor as to what he should put in Northwest Medicine "as long as it is his opinion" (R. 1161).

[9] Several of the individual appellees have been active in Northwest Medicine. Appellee Martzloff was a trustee from 1936 to 1949 (Gov. Ex. 1862, R. 125, 469; R. 5344); appellee McLean was a trustee from 1938 to 1949 and president of the board in 1946 (Gov. Ex. 1862, R. 125, 469; R. 5342). Appellee Hunt has served as associate editor (Gov. Exs. 337, R. 3126; 339, R. 3133; 364, R. 3218; 688, R. 3819; 717, R. 3908), and appellee Leitch was editor of the Oregon section from 1944 to 1949 (Gov. Ex. 1751, R. 5343).

[10] The State Society had a Committee on Publications whose activities relating to Northwest Medicine included discussions, meetings with the editors, and reports on the magazine to the Council or House of Delegates (Gov. Exs. 357, R. 3204–06; 368, R. 3227–8; 668, R. 3739; 1751, R. 5346–7). The

In addition to Northwest Medicine, the State Society also published during part of the period here involved a periodical called the Medical Reporter. This publication was supervised by the State Society's Committee on Publicity (e. g., Gov. Exs. 260, R. 2729; 263, R. 2741; 266, R. 2759; 269, R. 2772; 275, R. 2805).

b. The County Societies

The county medical society appellees are component societies of the State Society, being affiliated with it "to a limited extent" (Fdg. 3, R. 2018; Gov. Ex. 4, R. 2062). State Society officials and councilors frequenty address and attend county society meetings (Gov. Exs. 276, R. 2815; 280, R. 2893; 284, R. 2932; 717, R. 3910–11; 2103, R. 6452), and county society officers and members similarly participate in meetings of the State Society Council (Gov. Exs. 360, R. 3212; 375, R. 3252; 376, R. 3253; 382, R. 3289). Delegates to the House of Delegates report back to their local societies Gov. Exs. 277, R. 2847, 2853; 279, R. 2883, 2886; 1043, R. 4420). The State Society communicates its policies, recommendations and decisions to the

Council employed a doctor as editor of the Oregon section on a part-time basis (Gov. Ex. 333, R. 3111); appellee Leitch held that position from 1944 to 1949 (R. 5343).

An editor of Northwest Medicine has frequently been present at meetings of the House of Delegates and of the Council of the State Society (Gov. Exs. 280, R. 2889–90; 295, R. 3018; 296, R. 3018; 346, R. 3175; 352, R. 3197; 682, R. 3804; 683, R. 3809; 702, R. 3867; 1751, R. 5346).

local groups (Gov. Ex. 1751, R. 5337); minutes of the meetings of the Council have been sent to the component societies (Gov. Ex. 375, R. 3252). The local societies, in turn, frequently seek guidance from the State Society (Gov. Exs. 281, R. 2923; 296, R. 3019; 310, R. 3053; 1090, R. 4508).[11]

Some of the local groups have been chartered by the State Society (Gov. Exs. 6, R. 2098; 7, R. 2104–5; 9, R. 2113; 1751, R. 5336–7); component societies are bound by the Constitution and by-laws of the State Society (Gov. Ex. 4, R. 2071). The charter of any component society can be revoked by the State Society Council on certain specified grounds (Gov. Ex. 4, R. 2071–2).[12]

In most instances, members of the county society also belong to the state organization (Gov. Exs. 2031–2, R. 6200–6314; R. 1762). A member suspended or expelled from the county society also is considered suspended or expelled from the State Society (Gov. Ex. 4, R. 2063, 2069).

The Multnomah County Medical Society is the largest of the local groups. Comprising the doc-

[11] For instance, when Industrial Hospital Association wrote the Lane County Medical Society in 1938 to ascertain the society's attitude toward its activities, the society did not handle the matter directly but instead forwarded the letter to the Council of the State Society for advice as to the proper reply (Gov. Ex. 1975, R. 5098).

[12] These include "failure to comply with the policy of the House of Delegates or Council of this Society." (Gov. Ex. 4, R. 2072.)

tors practicing in metropolitan Portland, the largest city in Oregon, this society had between 600 and 700 members during 1949, or more than half the membership of the State Society (Fdg. 51, R. 2029; Gov. Exs. 2031–32, R. 6200–6314; 2191, R. 6602). It has been able to designate a majority of the members of the State Society's House of Delegates. This factor, together with the fact that a substantial number of the officers, Council members, and committee members of the State Society have been Portland doctors (Gov. Exs. 328, R. 3102; 1862, R. 114, 469; 2136, R. 6503), has given the Multnomah County Society an influential position in the State Society. The Multnomah society publishes a monthly bulletin (Gov. Ex. 1861, R. 219, 469).[13]

Generally, the constitutions and by-laws of the county medical societies in Oregon bind the members to conform to the policies and actions of the societies (Gov. Exs. 6, R. 2099; 9, R. 2114; 75, R. 2203; 1999, R. 6102).

c. Oregon Physicians Service (OPS)

Oregon Physicians Service, an Oregon corporation, operates a prepaid medical care plan (Gov. Ex. 1751, R. 5338). The corporation was organized by the State Society in 1941 (Gov. Ex. 1751, R. 5338; R. 1293–4). It is "sponsored and

[13] Since March 1947, the bulletin has contained a statement that opinions expressed therein are those of the writer and not necessarily those of the Society (Gov. Ex. 747, R. 3976).

approved" by the State Society (Fdg. 2, R. 2017–18).

OPS sells contracts for prepaid medical care under which, in return for a fixed monthly premium, the subscriber may be treated by any of the participating doctors he selects (Gov. Exs. 128, R. 2357; 129, R. 2360). Such policies cover or have covered [14] medical treatment, hospitalization, drugs and medicines, and dental and nursing care (Gov. Exs. 126, R. 2334–5; 129, R. 2360; R. 1674–5). Prior to performing extensive treatment or major surgery, the doctor is required to obtain OPS approval (Gov. Exs. 126, R. 2352; 196, R. 2541; 438, R. 3411; R. 1660–61).

The voting stock of the corporation is held by a group of trustees designated by the State Society (Gov. Ex. 1751, R. 5339), and its nonvoting stock by physicians throughout the State (*ibid.* R. 5340). Doctor participation in the program is limited to members in good standing of state or county societies.[15] By 1943, 85 per-

[14] See *infra*, pp. 91–92.

[15] In 1949, OPS informed a subscriber that since a particular physician (who had been expelled from the Multnomah County Medical Society for hospital association practice and denied OPS participation, see *infra*, pp. 46–50) was not a cooperating OPS doctor, it could not assume responsibility for his services (Gov. Ex. 1891, R. 5604).

Although it has been suggested that mere eligibility for medical society membership is sufficient for doctor participation (e. g., R. 1662; Gov. Ex. 5, R. 2094), the practice has been to restrict affiliation to actual members (Gov. Exs. 407, R. 3342; 459, R. 3454). In 1944, the OPS supervisory com-

cent of the Oregon doctors actively engaged in private practice were affiliated with the OPS program (Gov. Ex. 480, R. 3520), and since 1946, this figure has exceeded 90 percent (Gov. Exs. 453, R. 3436; 1220, R. 4739).[16] OPS is affiliated with, and conducted in cooperation with, the other medical society approved medical care plans in the state (Gov. Ex. 480, R. 3517).

OPS enters into separate contracts with each participating physician under which it agrees to pay him on the basis of a uniform schedule of fees (Gov. Ex. 197, R. 2543), although the percentage of the fees specified in the statewide schedule that are actually paid varies among counties,[17] and there

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mittee requested OPS to notify certain doctors that if they wished to remain as OPS staff doctors, they must join the county society (Gov. Ex. 494, R. 3536; *cf.* Gov. Ex. 2042, R. 6329). A 1947 agreement between the State Society and OPS provided that no physician was to become an OPS staff member "except upon the certification of the Society's secretary that such physician is a member in good standing of the said Society and/or of a component County or District Medical Society in the State of Oregon" (Gov. Ex. 444, R. 3420; *cf.* Gov. Exs. 407, R. 3342; 414, R. 3357; 459, R. 3454).

Two lists of cooperating physicians published by OPS in 1947 included 3 doctors who were not medical society members. These 3 were partners conducting a large industrial practice in Portland (R. 1866–71, 7511).

[16] The apparent discrepancy between these percentages and the percentage of Oregon doctors who are members of the State Society (*supra*, p. 12) reflects the different sources from which those figures were obtained.

[17] One of the counties, for example, at one time was reported to be paying 200 percent on all fees (Gov. Ex. 379, R. 3267);

may be occasional departures from the fee schedule in individual cases (Gov. Ex. 194, R. 2541).

OPS pursues an aggressive sales and promotion campaign (Gov. Ex. 2188, R. 6592). It has a substantial advertising budget (R. 1685), utilizes both press and radio coverage (Gov. Ex. 2188, R. 6593; R. 1685), and employs a staff of salesmen (R. 1687). Although the day-to-day administrative aspects of OPS activities have been conducted by lay employees (Gov. Ex. 125, R. 2327), policy direction and general supervisory authority have remained in the hands of the medical societies, primarily the State Society (Gov. Exs. 290, R. 2984; 372, R. 3243; 375, R. 3251-2; 502, R. 3547). In practice, the State Society controls statewide aspects of OPS, such as territorial allocations, fees, charges and coverage (Gov. Exs. 290, R. 2984; 372, R. 3243; 375, R. 3251-2), while local activities are governed largely by the component societies through their supervisory committees (Gov. Exs. 402, R. 3336; 780, R. 4050; 1751, R. 5340; R. 1296).

As of June 30, 1943, the end of its first year of operation, OPS had approximately 17,600 subscribers (Gov. Ex. 480, R. 3519). By June 30, 1949, this number had increased to 117,241 (Def. Ex. 2764, R. 7529).[18] Gross income for the

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in other areas, payments to physicians have been substantially less than the promulgated fees (Gov. Exs. 131, R. 2413; 257, R. 7228).

[18] In 1951, the number of subscribers had risen to 132,451. *Health Insurance Plans in the United States*, S. Rep. No. 359, Pt. 2, 82d Cong., 1st Sess. 194 (1951).

fiscal year 1942–3 was $800,200 (Gov. Ex. 480, R. 3521); in 1948 it was $3,602,271, or more than twice that of any competitor (Gov. Ex. 1267, R. 4866).[19] The State society estimated that in 1943, OPS and the other medical society sponsored plans covered 105,000 of the approximately 150,000 people in Oregon under prepaid medical care plans (Gov. Ex. 480, R. 3519; *cf.* Gov. Ex. 1559, R. 5203).[20]

d. Individual Doctor Appellees

Each of the individual doctor appellees has held executive positions with one or more of the organization appellees during this conspiracy (R. 87), and has actively participated in the conspiracy. In a separately bound Appendix we have summarized these affiliations and activities.

2. BACKGROUND OF THE PREPAID MEDICAL CARE BUSINESS IN OREGON.

For many years, prepaid medical care had been made available in Oregon by organizations known as hospital associations. These firms, operating under the provisions of a special Oregon statute,[21] sold medical care policies primarily to groups, but also to individuals (R. 1793, 1813, 1861). The group contracts were originally made

[19] In 1949, OPS' gross income had risen to $4,219,920. State of Oregon 42d Annual Report of the Insurance Commissioner, p. 64.

[20] At the time of the trial, this figure had become 200,000 out of an estimated 350,000. Health Insurance Plans in the United States, S. Rep. No. 359, Pt. 2, 82d Cong., 1st sess., 37; see R. 237.

[21] Oregon Compiled Laws Annotated (1940) §§ 101–901, *et seq.*

with employers and later were also made through unions to cover a number of employees (R. 455). Under the contracts, comprehensive medical care, including drugs and medical supplies, ambulance service and hospitalization, were supplied in return for a fixed monthly payment by each subscriber (Gov. Exs. 72, R. 2180; 77, R. 2204; 104, R. 2272).

Initially, each association had a panel of doctors to whom subscribers could go for treatment (*cf.* R. 585, 1000, 1063). In most instances, these doctors maintained their own offices and were paid by the association for treating subscribers on the basis of fees fixed by the association, although a few doctors were employed by the associations directly on a salary basis (R. 584, 689). In the thirties, the closed panel system was gradually abandoned [22] and some time before 1940 the associations had abolished it entirely (Gov. Ex. 1479, R. 5112–13; R. 378–9, 533, 585, 858). Any doctor in the State was eligible for participation, including chiropractors and osteopaths. (R. 445; *cf.* Gov. Ex. 2090, R. 6425). Pressure from the medical societies, however, at times led the associations to refuse participation by chiropractors,

[22] Not all doctors welcomed this process. Appellees' witness Dr. Hayes, who was active in medical society affairs with respect to prepaid medical care and contract practice questions (R. 1175, 1181), at an earlier period when he was on a panel, wrote to one of the associations urging that there was "no reason" to add another doctor to the panel in his town (Gov. Ex. 2129, R. 6496).

although their services were desired by subscribers (Def. Ex. 2696, R. 6971). Doctors were required to obtain approval from the association in advance of performing extensive treatment or major surgery to insure payment for such services (R. 1001, 1078, 1095).[23]

These associations were operated for profit. Five such associations were functioning at the beginning of 1936: Industrial Hospital Association, National Hospital Association, Oregon Medical Service, Inc. (also known as the C. H. Weston Co., Inc.), Prudential Hospital Association, and the Pumphrey Company (Gov. Ex. 1263, R. 4812). Prudential was entirely doctor-controlled. Three of Industrial's 4 stockholders were doctors (R. 356), and before the end of 1938, all its stockholders were doctors (Gov. Exs. 1659, R. 5299; 1662, R. 5301).

Medical care was also furnished to members of certain fraternal organizations, including the Eagles and Moose, through a system of organization physicians (Gov. Ex. 1254, R. 4782; R. 781–2). Railroad employees also received medical care from doctors employed by the railroad under contract (Gov. Exs. 293, R. 3011; 691, R. 3828). There were also a few local medical society sponsored prepaid medical care organiza-

[23] The record shows, however, numerous instances where doctors were paid by the associations even though admonished for not securing prior authority (e. g., Def. Exs. 1937, R. 6756; 2567, R. 6786; 2638, R. 6876).

tions (Gov. Ex. 1751, R. 5338), as well as some individual doctors contracting with employers to provide medical care to their employees (Gov. Ex. 1889, R. 5577, 5583, 5592).

This system of medicine is known by the profession as "contract practice," i. e., an arrangement under which the doctor furnishes medical services to a group of individuals on the basis of a fee schedule, or for a salary or fixed per capita rate (Gov. Ex. 2, R. 2057). Contract practice thus is distinguished from private patient practice where the doctor is paid on an individual fee basis determined between him and the patient.

3. THE MEDICAL SOCIETIES' POWER OVER DOCTORS

The source of the medical societies' power over doctors lies in the serious consequences of their expulsion from, or inability to join, the societies. Membership in a medical society is a prerequisite to the taking of specialty board examinations which qualify a doctor to hold himself out and to be accepted by the profession as a specialist in a particular field (Gov. Ex. 1226, R. 4748).[24] Non-members find malpractice insurance more difficult to obtain (R. 865–866), and its cost is substantially higher than to members (Ex. 1091,

[24] For a discussion of the importance to a specialist of taking specialty board examinations, see *Medical Economics*, Feb. 1950, p. 99.

R. 676, 865).[25] Access to and advancement on hospital staffs is more difficult for non-members,[26] and post-graduate or "refresher" training may be impeded (R. 866).[27] A non-member may have less access to medical society sponsored scientific meetings (*Ibid.*). Unless he was a member of the society, an Oregon doctor could not participate in many of the medical-society sponsored medical care plans, including OPS (see p. 17, *supra*). Finally, there is the significant social factor involved in a doctor being cut off from his professional organizations.[28]

The benefits of medical society membership were deemed sufficient by a large number of Oregon doctors to lead them to give up hospital association

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[25] A doctor who resigned from the medical society under pressure testified that costs of malpractice insurance were 35 percent more thereafter (R. 865).

[26] A doctor who had been expelled from the Multnomah County Society was asked not to, and did not, run again for Head of the Staff of St. Vincent's Hospital because he was not a member of the Society (R. 680). This hospital does not grant staff privileges to doctors who are not members of the medical society (Gov. Ex. 1856, R. 468, 1967, 1977). Although doctors who had been on the staff prior to disciplinary proceedings by the appellees were not required to leave the staff, they could not become officers or members of the Board of Governors (*Ibid.*).

[27] A doctor who had resigned from the Multnomah Society after charges of unethical practice had been preferred against him withdrew from his teaching position at the medical school (R. 865).

[28] It has been said, "To the average doctor in the small community, the county medical society is a most important element in both his profession and his social life." Michael M. Davis, *American Organizes Medicine* (1941), p. 163.

practice when threatened with disciplinary action (see *infra,* pp. 47–50). As one doctor expressed it: "Inasmuch as * * * continuation of it [contract practice] would be at the price of membership in the society there was nothing left for me to do but submit to your dictates and rulings; I told you that I prized my membership more than the small amount of such work I was doing * * *" (Gov. Ex. 1952, R. 5949; *cf* Gov. Ex. 1006, R. 4389).

4. THE MEDICAL SOCIETIES' ACTIONS TO COMBAT NON-MEDICAL SOCIETY SPONSORED PLANS

a. The formation of a medical society sponsored plan in Multnomah County

Although hospital associations had been operating in Oregon since 1904 (R. 689), it was not until the depression that the medical society appellees actively opposed them (Gov. Ex. 1057, R. 4438). Members of appellee Multnomah County Medical Society, noting that "much industrial work went to hospital associations," reasoned that "with a physician-owned association * * * they could attract much of the work which was going to the then organized hospital associations * * *." Gov. Ex. 208, R. 2563). Accordingly, in 1932, they organized Multnomah Industrial Health Asociation,[29] a doc-

[29] The name of the group was changed to Oregon Medical Service Bureau in 1938 (Gov. Ex. 741, R. 3964) and subsequently to The Multnomah Medical Service Bureau (Gov. Ex. 756, R. 3994). Eventually it merged with OPS (R. 1656).

tor-owned prepaid medical care plan whose coverage was limited to the so-called "low income group" earning not more than $1500 a year. (Gov. Exs. 208, R. 2563; 216, R. 2686; 274, R. 2796). "It was hoped that ultimately the commercial hospital associations * * * might be driven from the field" (Gov. Ex. 208, R. 2563).

Although the plan initially was supported by the Multnomah County Society, a schism soon developed among the membership over continued support (*ibid.*, R. 3564). The issue was "brought to a head" when the plan extended its coverage to school teachers, a "class who earned over $1500 a year." Also objectionable to many doctors was the fact that under the plan they had to care for their "former pay patients" at the "low net fees" which the plan paid, and that "in order to meet the competition of other like organizations" the plan had to cover certain executives earning "more than $1800 a year (*ibid.*)." In 1934, a committee was appointed by the Multnomah County Society under the chairmanship of appellee Martzloff "to investigate all hospital associations and especially the Multnomah organiation" (*ibid.*; Gov. Ex. 274, R. 2797).

The report of the Committee (the so-called "Martzloff Report"),[30] submitted in October 1935 (Gov. Ex. 274, R. 2797), and approved by

[30] This report was mailed to every member of the Multnomah County Medical Society (Gov. Ex. 246—not printed).

both the Council and membership of the Multnomah County Society (Gov. Ex. 208, R. 2566), condemned the plan as violating the Principles of Medical Ethics. It recommended "that disapproval be expressed of the affiliation of members of our Society with commercial hospital associations, including the Multnomah Industrial Health Asociation, in violation of 'the Principles of Medical Ethics'[31] and the Society's Constitution and By Laws, to the extent of expulsion from the Society, after present outstanding con-

[31] Standards governing contract practice are set forth in the Principles of Medical Ethics of the American Medical Association (Gov. Ex. 2, R. 2057–8). These Principles have been adopted by the State Society and appellee county societies as their codes of professional conduct (Gov. Exs. 6, R. 2098; 7, 2106; 1751, R. 5335, 5337).

The Principles, constituting a detailed set of professional standards, cover such topics as deportment, relationships with patients and among physicians, consultations, duties of the profession to the public, and compensation. Contract practice is discussed under this last heading. The Principles state that contract practice "per se" is not unethical, but list 7 conditions under which a contract may be unethical, including "when the compensation is inadequate to assure good medical service," or "when there is interference with reasonable competition in a community." The decision as to whether a particular contract is ethical or unethical "must be based on the ultimate effect for good or ill on the people as a whole."

The Principles condemn as "unprofessional" the disposal by a physician of his professional service to any lay body under terms which permit a "direct profit" from his compensation to accrue to such lay body on the ground, *inter alia*, that such conduct "is unfair competition with the profession at large." They similarly condemn disposal by a physician of his services "under conditions which interfere with reasonable competition among the physicians of a community" (Gov. Ex. 2, R. 2057, portion not printed).

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tracts have expired."[32] (Gov. Ex. 209, R. 2575). The report stated that the operations of the doctors' plan (*ibid.*, R. 2569–70):

> have resulted in a decreased income for that part of the profession within the Multnomah Industrial Health Association from patients who are able to pay customary fees and in the loss of some of these patients by doctors outside the Association * * * The coverage of this group of persons by the Association has deprived their family physicians of a source of income to which the latter are entitled and were receiving until the advent of the Association.

The report also pointed out that the plan's operations "have had no appreciable effect on the proprietary hospital associations and its subscribers have been largely drawn from groups who have never before been brought under a scheme of contract medicine." (*Ibid.*, R. 2570.)

Although the Martzloff report caused a division among the doctors in the Multnomah County Society, there was no disagreement over the continuation of the campaign against the hospital

[32] The Multnomah County society at that time also withdrew its previous approval of the Multnomah Industrial Health Association (Gov. Ex. 208, R. 2566). The association subsequently changed its operating procedures to eliminate those features found objectionable by the society, and, in 1938, was approved by the latter as the organization to provide medical care for low-wage industrial groups (Gov. Ex. 756, R. 3993).

associations. The division was solely as to the tactics to be employed. Some doctors "were opposed to hospital associations and contract practice in any form"; the others "believed that an organization such as the Multnomah, with the backing of the county society and meeting the organizations on their own ground, could drive the other commercial organizations from the field" (Gov. Ex. 208, R. 2564–5).

About this time, members of the Jackson County Medical Association formed the Southern Oregon Medical Service Bureau (R. 1007, 1021). This prepaid medical care plan "had been organized to destroy the lay-controlled hospital associations," and it was thought that if all members of the Society could be induced to "refuse to serve" the hospital associations, the members would "drop" their own plan (Gov. Ex. 298, R. 3020; *cf.* Gov. Ex. 947, R. 4327).

b. Organization of the campaign—Publication of the Medical Societies' attitude—Employment of counsel

After the president of the Multnomah County Society had outlined before the Council of the State Society the problems faced by his Society in connection with the "unethical" practices of numerous members (Gov. Ex. 292, R. 3007), the Council, in February 1936, adopted almost verbatim a statement of policy concerning the enforcement of the Principles of Medical Ethics that had been drafted by appellee Fitzgibbon

(Gov. Ex. 293, R. 3013–4). This statement was published in the Medical Reporter (Gov. Ex. 266, R. 2760) and was sent, together with a "Call Against State Medicine," a copy of the Principles,[33] and excerpts from decisions of the AMA's Judicial Council dealing with contract practice, to every member of the State Society (Gov. Ex. 276, R. 2816).[34]

The statement pointed out that the State Society's bylaws required the Council to act as the Board of Censors and to "consider and act upon all questions of an ethical character" (Gov. Ex. 662,

[33] An article in the Medical Reporter in July, 1936, pointed out that the Principles "contain definite economic implications" (Gov. Ex. 272, R. 2780).

The Principles of Medical Ethics also were sent to every member of the State Society in October 1944 (Gov. Ex. 360, R. 3211).

[34] The Medical Reporter in December 1935 had advised Oregon doctors that the American Medical Association considered the hospital associations to be unethical (Gov. Ex. 264, R. 2746), and, in 1936, at a meeting of the Council of the State Society, a council member who was also a trustee of AMA had pointed out that disciplinary proceedings had been used in various parts of the country to meet this problem (Gov. Ex. 292, R. 3008). Appellee Fitzgibbon, in 1936, as Oregon delegate to AMA, "appeared before the Board of Trustees [of AMA] and informed that body of difficulties in enforcement of medical ethics in relation to hospital association practice in this community" (Gov. Ex. 276, R. 2820), and Oregon doctors were advised that at the February 1936 meeting of the State Society Council, "The organization of hospital associations in various parts of the state was discussed and it was felt that these organizations were operating in contravention of the decisions of the Judicial Council of the AMA" (Gov. Ex. 294, R. 3016).

R. 3688). Through the statement, the Council indicated that "the time has come" when it is "incumbent upon it to make a definite pronouncement concerning the enforcement of The Principles of Medical Ethics" (*ibid.*, R. 3688–9):

> With the advent of the depression and the consequent curtailment of physicians' incomes, members of many component local societies were led to an analysis—which should probably have been made long before—of all the various causes leading to the impoverishment of the physician. Among these causes were found the activities of the commerical hospital associations, by reason of the fact that they had secured in some local communities a partial monopoly of medical practice among the employees of the larger industrial concerns. Hand in hand with this development was the increasing solicitation by the commercial hospital associations, which heretofore had largely limited their activities to the lumber industry, and other industrial operations in isolated localities far removed from existing professional and hospital services, of a new class of business in towns and cities where medical service was readily available to all under the usual conditions of private practice. (R. 3692.)

It was announced that the Council was "especially concerned" with the "widespread violations" of the Principles of Medical Ethics by the "commercial associations," and that the

State Society felt it had a "duty * * * to assist its component societies to keep their houses in order" (*ibid.*, R. 3694–5).

> The Council therefore, at this time earnestly solicits your cooperation and the assistance of your component society in eliminating or reducing to a minimum the various violations of "The Principles of Medical Ethics." It is our firm belief that action in this direction is the first step in staying the present trend. [Gov. Ex. 661, R. 3685.]

The Council urged that the local societies take certain suggested action. Members of such societies "engaged in unethical contract practice" were to be "requested to cease such activities and to conduct themselves in accordance with The Principles of Medical Ethics" (Gov. Ex. 662, R. 3696).

The county societies followed these suggestions. Numerous meetings were held at which representatives of the State Society discussed the applicability of the Principles of Medical Ethics to contract practice (Gov. Exs. 280, R. 2893; 296, R. 3019; 299, R. 3023).[35] Under a statement of

[35] Dr. Morris Fishbein of the American Medical Association addressed a meeting of the Multnomah Society in 1936 on ethical practice (Gov. Ex. 274, R. 2802; R. 576, 1355). A former president of the State Society charged that Dr. Fishbein "came out here and stirred up more trouble than any man who ever came into the State of Oregon * * *" (Gov. Ex. 1859, R. 298, 468).

principles adopted by the State Society in 1936, members of the component societies were to submit any proposed medical service contracts to the executive committee of the Council for approval (Gov. Exs. 277, R. 2847; 303, R. 3028; 304, R. 3033). In June, 1936, appellee Hunt discussed before a Council meeting the efforts of certain local societies "to deal with unethical contract practice, in accordance with the recently adopted policy of the Council * * *" (Gov. Ex. 301, R. 3026). In the next month he informed the Council that (Gov. Ex. 702, R. 3869, italics added)

> * * * an effort had been made in Lane County to unite all the members of the local medical society in an organization to provide contract service. He said that this step created a vicious circle of competition with the physicians in the newly-organized association performing service for the older, lay-owned associations, thus competing with their own organizations. Dr. Hunt called attention to the dangers of family contract which was being offered to some extent in his county. He stated that Lane County Medical Society was attempting to work out a solution, which was *planned to include the elimination of the lay-owned hospital associations*, the limitation of contract service to industrial concerns, and *obtaining the cooperation of the hospitals in refusing to provide service*

to the patients of lay-owned hospital associations. * * *

The State Society continued its leadership of the campaign against "unethical" contract practice. An inquiry made by it to the AMA respecting the issuance of charters to component societies arose "out of a movement to curb unethical practice in various localities of the state by bringing to bear the influence of our Society through its power to issue charters requiring conformity to the Principles of Medical Ethics by the membership" (Gov. Ex. 2002, R. 6106). The 1936 meeting of the House of Delegates recommended that each component society devote certain of its meetings during 1937 "to a discussion of problems of medical economics and the policies of organized medicine with relation thereto." (Gov. Ex. 277, R. 2847.) At its February 1936 meeting, the Council concluded, after discussion, that the hospital associations "were operating in contravention of the decisions of the Judicial Council of the AMA." (Gov. Ex. 294, R. 3017.)

The State Society advised its membership in December 1936 that the Council had authorized the employment of legal counsel to advise the local societies on the interpretation and enforcement of the "established regulations" of the State Society and the AMA (Gov. Exs. 276, R. 2316; 292, R. 3006; 294, R. 3016). The attorney's services were made available by the Council in subsequent years "to all component societies which

were faced with problems arising from unethical contract practice." (Gov. Ex. 323, R. 3088.)[36]

"Unethical contract practice" continued to be a subject of discussion at state and county society meetings during the remainder of 1937 and for the next two years. (Gov. Exs. 304, R. 3037; 313, R. 3055; 314, R. 3057; 315, R. 3060; 1968, R. 5984.) The State Society reminded the local societies of their duties in respect thereto. Thus, in 1937, letters were sent to the component societies calling their attention to the Principles and the pronouncements of AMA and the State Society relating to contract practice, and soliciting their cooperation in procuring observation of those standards. (Gov. Ex. 310, R. 3053.) A grievance committee was created to investigate and present charges of unethical conduct (Gov. Ex. 304, R. 3038), and a special committee to study contract practice problems in local communities was also formed (Gov. Ex. 664, R. 3704). In 1937, appellee Hunt notified the State Society of progress in eradicating "unethical contract practice" in his district, which consisted of several counties (Gov. Ex. 313, R. 3055).

Articles in Northwest Medicine informed the profession of the "progress" being made in eliminating "undesirable practices." A 1937 article was entitled "Elimination of Contract Practice."

[36] This attorney prepared an outline of procedure to be followed by component societies in connection with the discipline of members (Gov. Ex. 202, R. 3006–3007).

(Gov. Ex. 315, R. 3060.) In 1938, the periodical reported that the Council in the last two years had assumed the leadership in assuring a return by the component societies "to a reasonable observance of ethical principles," and that "notable progress" had been made by a number of local groups (Gov. Ex. 323, R. 3088).

c. The aim and efforts of appellees to vest control of all prepaid medical care plans in the organized medical profession

During this early period of the conspiracy, the State Society's public pronouncements and actions made clear that its aim to eliminate the hospital associations and limit prepaid medical care plans to those under the control of the medical profession. An article in the August 1936 issue of Northwest Medicine, dealing with the Multnomah County doctors' plan, ended with a call for "living up to promises * * * especially in the matter of making a clean sweep of all hospital associations * * *" (Gov. Ex. 208, R. 2566). A report submitted by the State Society's committee on Medical Economics, it was announced in the May 1938 issue of Northwest Medicine, expressed the opinion "that some plan [of prepaid medical care for the low income group] should be developed by the society to replace the existing schemes of lay hospital associations and groups of physicians." (Gov. Ex. 2085, R. 6414; *cf.* Gov. Ex. 702, R. 3869.)

The State Society's 1937–1938 studies of medical care for low income groups, upon which the foregoing report was based, had emphasized that plans for such care should be under the control of the medical profession. The report recommended that the State Society engage in statewide contract practice through a corporation controlled by the society (Gov. Ex. 667, R. 3734).[37]

In 1940, the State Society Council passed a resolution that the Council "do not approve the plan of any hospital association that is not owned and controlled by physicians" who are members of their local and state society (Gov. Exs. 341, R. 3148; 350, R. 3183). A letter sent in 1940 by appellee Hunt, as president of the State Society, informed the membership that "Any plans for medical care of the low-income patient should be solely in the hands of the medical profession." (Gov. Ex. 340, R. 3138.) By 1941, the "established policies" of the State Society included the principle that "Medical care for certain groups can be approved if this care is provided by physician owned and controlled service bureaus." (Gov. Exs. 712, R. 3697; 713, not printed.) As recently as 1946, the House of Delegates passed

[37] In 1938, the State Society's committee on medical economics had prepared articles of incorporation and by-laws for a state corporation to engage in supplying prepaid medical care. The committee recommended that the voting stock be owned by the State Society since "no [other] adequate method of controlling the activities of such a corporation appeared possible" (Gov. Ex. 664, not printed).

a resolution that it "shall be the policy" of the State Society "to have all contracts for medical service made in and through the profession's own prepaid organization, the Oregon Physicians Service and not with any private doctor or group of doctors" (Gov. Ex. 287, R. 2957; *cf.* R. 2960).[38]

The implementation of the medical society policy of exclusive control over all prepaid plans by the organized profession is graphically illustrated by the story of what happened to Dr. Chester Moore, the President and Medical Director of Industrial Hospital Association (R. 355). In 1936, charges of unethical conduct were filed against him by the Grievance Committee of the Multnomah County Society because of his contract practice with the association. After a hearing by the Board of Censors, it was recommended in December 1936 that Dr. Moore be expelled (Gov. Ex. 878, R. 4236), although in the interval Industrial had taken steps to eliminate its single lay stockholder by purchasing his stock (Gov. Ex. 1657, R. 5295). This recommendation was upheld by the Council of the Multnomah Society, and Dr. Moore resigned the same day (Gov. Ex. 879, R. 4237; Gov. Ex. 880, R. 4239).

Subsequent endeavors by Dr. Moore to develop a method of operation for Industrial that would

[38] Delegates from the Oregon Medical Societies were among the few groups that opposed at the 1949 AMA convention adoption of an AMA set of standards for approval of cooperative prepaid medical care organizations (Gov. Exs. 2064, R. 6374; 2101, R. 6447).

meet with medical society approval were unsuccessful (Gov. Exs. 799, R. 4089; 882, R. 4242; 833, R. 4243; 884, R. 4244; 886, R. 4248; 887, R. 4249; 1750, R. 5332).

By 1940 the Council of the State Society had appointed a committee "to attempt to take over the Industrial Hospital Association to be operated by approved local associations" (Gov. Ex. 345, R. 3174). In the same year appellee Hunt wrote to one of Dr. Moore's partners in Industrial (Gov. Ex. 889, R. 4251, italics added):

> * * * As you know according to our adopted policies, there is to be but one approved Medical Service Bureau in a county or district and all the doctors in that locality who care to serve are to be members. This local bureau must first have the approval of the local county society before the State Society can approve it.
>
> It seems to me the greatest hurdle to overcome, is the fact that you are operating state wide and in competition to approved local bureaus. This is a thing we are trying to overcome. The fact that your organization is physician owned, gives free choice of physician and pays good fees are all steps in the right direction, *but it seems to me that the Society cannot approve competing organizations throughout the state even if they are physician owned* * * *.

Only OPS and the other medical society sponsored plans have been approved by the State Society (Gov. Ex. 3, R. 2059).

Medical society control over prepaid medicine has been strengthened by the provisions in many of the medical society sponsored plans prohibiting participating doctors from serving non-society approved plans. Doctors who had joined the Multnomah Industrial Health Association had pledged themselves not to sell their services to lay owned hospital associations (Gov. Exs. 19, R. 2129; 206, R. 2558; 216, R. 2688).[39] Similar limitations were imposed by other local medical society sponsored plans. For example, upon organization of the Physicians Association of Clackamas County in 1936 or 1937, when the doctors there "all revolted" against further work for the hospital associations (R. 1098), they "agreed" that they would "service" only their own contracts (R. 1101; *cf.* Gov. Ex. 1498, R. 4717). All but one or two of the doctors in that county belong to the association (Fdg. 51, R. 2029; R. 1114).

[39] In 1939, a doctor member of the group, after receiving notice that the stock of staff physicians who rendered services for "unapproved hospital associations" would be repurchased pursuant to the bylaws, terminated his work for National. He stated that he was "sorry," but that it would be "impossible," in view of the notice, for him to continue to work for National (Gov. Ex. 1759, R. 5353; see also Gov. Exs. 19, R. 2129; 1984, R. 6073).

In 1938, a State Society policy statement relating to medical care for low wage groups proposed that each local plan for such care "shall include a prohibition against any physician who participates in the plan from engaging in activities which tend to defeat the purposes of the plan" (Gov. Ex. 667, R. 3736). In 1939, the Council decided that no local plan should be approved by the Council as affiliated with the Bureau of Medical Economics if it included any doctors who participated in a prepaid medical care plan not approved by the local society and the Council (Gov. Ex. 338, R. 3131). Consistent with this policy, the by-laws of OPS, since its organization by the State Society in 1941, have prohibited affiliated physicians from serving non-approved medical care associations (Gov. Ex. 896, R. 4259).[40]

d. Disciplinary proceedings against doctors

The district court found: that "Prior to 1941, defendant Multnomah County Medical Society expelled certain members who were associated with certain types of contract practice and

[40] In 1944, this policy was referred to by appellee Baum's office in returning a National check. It was explained that "* * * since the doctors here are under contract with Oregon Physicians' Service, they are not allowed to accept checks from any other Hospital Association" (Gov. Ex. 33, R. 2140; *cf.* Ex. 49, R. 2157). *Cf.* R. 801. In 1948, OPS was instructed by the Multnomah County Supervisory Committee of OPS not to honor bills from laboratories not operated by OPS doctors (Gov. Ex. 846, R. 4183–84).

threatened the expulsion of other members so engaged, but such action by said defendant society was not the result of any combination, agreement or conspiracy in restraint of trade or commerce or otherwise and was for the purpose of maintaining and advancing the standards of medical practice of members of said defendant society; and no other defendant has ever expelled, threatened or incited the expulsion from medical societies of any doctors because of any cooperation in prepaid medical care plans, and since 1941, none of the defendants has expelled, threatened or incited the expulsion from any medical societies of doctors cooperating in medical care plans other than those sponsored by defendants" (Fdg. 23, R. 2037–38).

The uncontradicted evidence is that: The Martzloff Report had recommended disapproval of Multnomah County society members' affiliation with commercial hospital associations "to the extent of expulsion from the Society" (Gov. Ex. 209, R. 2575). In March 1936, the Council of that society called upon those of its members engaged in hospital association work "as active members, or as consultants" to "sever their connections with all such forms of practice." It also sent out a questionnaire asking the members whether they would join in an agreement not to do any work for such associations (Gov. Exs.

269, R. 2772; 724, R. 3926). Disciplinary proceedings were instituted soon thereafter.

Although particular disciplinary proceedings were initiated at the county society level, the State Society encouraged and assisted the county societies in taking or planning disciplinary action. In 1936 or early 1937, the State Society prepared through an attorney (Gov. Ex. 292, R. 3006) and distributed an outline of procedure for the proper conduct of disciplinary proceedings in cases of "unethical contract practice", and announced its readiness to assist and advise the local groups "on any aspects of disciplinary action" (Gov. Ex. 665, R. 3714, 3721).[41] This offer of aid to the county societies was accepted, for, in January 1940, the State Society, at the request of the Clatsop County Society, suggested a resolution for adoption by the latter which provided that members who associate with plans which are "unethical in their nature" will be "subject to disciplinary proceedings" (Gov. Ex. 1981, R. 6063).

In December, 1939, the Council directed that "unethical practices" in certain localities should

[41] Previously, the House of Delegates had adopted the recommendation of Olin West, Secretary of AMA, that each component society review and conform its constitution and by-laws to harmonize with those of the State Society "particularly with regard to disciplinary procedure" (Gov. Ex. 277, R. 2846–7).

be "scrutinized" by the local societies and "disciplinary action" taken against any members whose practices were found to be "unethical."[42] The Council warned that unless the local societies "invoke proper disciplinary proceedings" against members engaged in such practices, their affiliation with the State Society would be "jeopardized." It set the date for institution of such disciplinary proceedings as January 1, 1940 (Gov. Exs. 65, R. 2167; 339, R. 3135; 1427, R. 5020; 1980, R. 6061; R. 503).

A letter containing this ruling was sent to all county societies and to individual doctors (Gov. Exs. 65, R. 2166–2167; 1427, R. 5020; 1980, R. 6061; R. 503), at a time when a large number of disciplinary proceedings already had been had in Multnomah County and had been under consideration elsewhere.[43] Upon receipt of this letter, the Jackson County Medical Society, at its December 1939 meeting, passed a motion "that members doing work for lay-owned organizations be dropped from membership" (Gov. Ex. 967, R. 4347). The Lane County Medical Society's re-

[42] In 1937, the Oregon section of Northwest Medicine had stated that "The profession throughout the state is watching with interest the example set by their largest component society and will not be slow in purging themselves of similar unethical acts carried on by some of their members" (Gov. Ex. 307, R. 3048–9).

[43] The proof does not show that actual disciplinary proceedings were conducted by any society other than Multnomah County though, as to reviewing authority, the State Society affirmed Multnomah's expulsion orders. See note 46, *infra*, p. 45.

sponse to the letter was passage of a resolution at its December 15, 1939 meeting declaring it to be the society's "policy" "to employ disciplinary measures" in cases of members associating with hospital associations disapproved because of some activity "unethical in nature"[44] (Gov. Ex. 1016, R. 4395).

Not only did the State Society encourage the county societies to aid them in taking disciplinary action, but it asserted original jurisdiction over such proceedings. In 1937, the Council voted to exercise "original jurisdiction in unethical situations brought to its attention"[45] (Gov. Ex. 280, R. 2896). The State Society previously had announced that "in some instances, it becomes the duty of the State Society to see that disciplinary measures are taken" (Gov. Ex. 665, R. 3721). In addition, under its constitution, the State Society also had appellate jurisdiction over disciplinary proceedings (R. 1124, 1935).[46]

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[44] In 1937, the Lane County Society had passed a resolution that further work done for "unethical hospital associations" would be "cause for expulsion" (Gov. Ex. 1005, R. 4388).

During this conspiracy a number of doctors concealed from the medical societies the fact that they were dealing with hospital associations (R. 499, 1836–7, 1900–1).

[45] At the same time it created a grievance committee to investigate and report to it on such situations (Gov. Ex. 280, R. 2896).

[46] *E. g.*, when two doctors were expelled from the Multnomah County Society in 1936 because of their contract practice with Prudential (Gov. Exs. 1060, R. 4460; 2029, R. 6176), the State Society reviewed and affirmed the expulsions (Gov. Exs. 1062, R. 4462; 1949, R. 5932).

During the years 1936 to 1940, a substantial number of doctors were subjected to disciplinary proceedings by the Multnomah County Medical Society because of their affiliation with "unethical" hospital associations.[47] During the first six

[47] Although technically the disciplinary actions were for alleged violations of the Principles of Medical Ethics, such violations arose out of affiliation with the "unethical" hospital associations.

The typical letter sent to a doctor by the Multnomah County Medical Society initiating disciplinary proceedings stated that it had "received information which appears to indicate that the contract practice engaged in by you in connection with [named or "certain"] hospital associations is conducted in a manner which is in violation of the Principles of Medical Ethics" (Gov. Exs. 1081, R. 4489; 1952, R. 5945; 1958, R. 5959; 1965, R. 5976). The following are excerpts from a typical report of the Grievance Committee of MCMS to the Society's secretary (Gov. Ex. 1910, R. 5617):

"We have carefully examined certain evidence presented to us regarding the contract practice of the C. H. Weston Company and that of Dr. H. R. Shields in connection with that company. We have also carefully considered the statements and testimony presented by Dr. Shields at the preliminary investigation held by the Board of Censors on November 2, 1936.

"It appears from this evidence and the above-mentioned statements and testimony that there is evidence that the contract practice engaged in by Dr. Shields in connection with the C. H. Weston Company is in violation of the Principles of Medical Ethics of the American Medical Association.

"It therefore becomes our duty as the duly appointed Grievance Committee of our society to prefer the following charges against Dr. Shields:

* * * * *

"4. That Dr. H. R. Shields has violated Chapter III, Article VI, Section 4 of the said Principles of Medical Ethics in that Dr. Shields disposes of his professional attainments or services in such a manner

months of 1938, for example, 30 members of the society were summoned to appear before the censors (Gov. Ex. 744, R. 3970). As a result of these disciplinary proceedings, 7 doctors were expelled (Gov. Exs. 1977, R. 6047–8; 2029, R. 6176), 2 were suspended (Gov. Exs. 1910, R. 5616; 1930, R. 5709), and at least 5 others resigned from the society after the censors had recommended their expulsion (Gov. Exs. 729, R. 3939; 880, R. 4240; 1076, R. 4483–5; 1889, R. 5561).[48] Moreover, these disciplinary proceedings received a great deal of pubilicity (Gov. Exs. 1740–1, R. 5327–28) and many doctors gave up contract practice without actually having been formally disciplined after being called before the censors.[49]

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as *to permit a direct profit from the fees, salary or compensation received to accrue to the C. H. Weston Company and its stockholders*, all of whom are laymen." [Italics supplied.]

[48] At least one other doctor resigned after having been subjected to preliminary disciplinary proceedings (Gov. Ex. 1074, R. 4482; R. 861–3).

[49] E. g. Gov. Exs. 45, R. 2155; 1760, R. 5354; 1952, R. 5945; 1953, R. 5950; 1954, R. 5951; 1958, R. 5959; 1965, R. 5976; 1966, R. 5979; 1969, R. 5988; 1971, R. 5992; 1972, R. 5993; R. 1502.

The attitude of the doctors who gave up contract practice in the face of threatened disciplinary action is illustrated by the following letter to the Multnomah County Board of Censors (Gov. Ex. 1952, R. 5949):

* * * * *

Inasmuch as admissions of type and kind done is in your opinion and interpretation contrary to the tenets of the society and that a continuation of it would be at the price of membership in the society there was nothing

Among those thus resigning under pressure was Dr. Moore, the president of Industrial Hospital Association (see pp. 38–40, *supra*). Dr. Suckow, another of the doctors thus resigning, sought readmission several years later. His application was denied in 1942 (Gov. Ex. 771, R. 4030), but in 1945, after he had terminated his hospital association work (R. 647), he was readmitted (Gov. Ex. 1116, R. 4641). Other doctors connected with hospital associations were unsuccessful in their attempts to join the society (Gov. Exs. 1959, R. 5943; 2031, R. 6227; R. 677, 864–5).[50]

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left for me to do but submit to your dictates and rulings; I told you that I prized my membership more than the small amount of such work I was doing and that therefore I would agree to discontinue further work of the nature.

* * * * *

In keeping with your dictum this is formal declaration of my intention to abide by the rules as you interpret them.

Another doctor ended his letter to the Grievance Committee announcing his intention to discontinue work for National with the following words (Gov. Ex. 1969, R. 5990–91):

Being a Urologist—My training in examining "urine" has been quite extensive and altho different vessels may vary slightly in smell the odor is characteristic. Only the rose has the distinction; "That by any other name would smell as sweet." You gentlemen are not defending a Rose.

[50] Applications for admission by three doctors affiliated with the Permanente Foundation (see pp. 81–82, *infra*) have not been processed and have been held up pending the outcome of this case (Gov. Exs. 792–3, R. 4075–77; R. 746–9, 1519–21).

Physicians subjected to disciplinary action in 1936 included four doctors on the staffs of the Pumphrey and the Weston companies, two prepaid medical care organizations that had been doing business in Oregon for many years.[51] The two doctors employed by Pumphrey agreed to leave the organization after they had been charged with unethical practice (Gov. Ex. 1962, R. 5973–4). One resigned, the other did not, and he was expelled in 1937 (Gov. Ex. 1976, R. 6013–19; 1977, R. 6047–8). The Pumphrey Company found it "practically impossible" to obtain doctors to service its accounts between 1936 and 1940 (R. 569; see note 66, *infra*, p. 61). As a result, Pumphrey lost "practically all" of its accounts (R. 660), and ceased to do business in 1940 (R. 656). See *infra*, note 66, p. 61.

The two Weston physicians similarly agreed to leave their company after hearings before the censors (Gov. Exs. 1915, R. 5621; 1919, R. 5637). Apparently they failed to do so, because the charges against them were renewed (Gov. Exs. 1907, R. 5615; 1922, R. 5703), and they were suspended in November 1937 (Gov. Exs. 1910, R. 5616; 1930, R. 5709). They were reinstated in April 1938, after they had left Weston (Gov. Exs. 1911, R. 5618; 1912, R. 5619). In 1938,

[51] The Pumphrey Company had been in business since 1926 (R. 656). By 1934, it was the third largest prepaid medical care organization in the State (Gov. Ex. 221, R. 2706). The Weston Company had been conducting a prepaid medical care business in Oregon since 1904 (R. 689).

1939 or 1940 the Weston Company, after it had lost the services of these two staff doctors, went out of the prepaid medical care business (R. 689, 691).[52]

Although no formal disciplinary proceedings were conducted after 1940, their threat always remained in the background. In 1945, the House of Delegates suggested that if doctors failed to follow a policy of treating railroad and industrial contract cases as private patients, "other remedies may be applied" (Gov. Ex. 716, R. 3907). In the same year, the Multnomah County Society recreated a grievance committee (Gov. Ex. 779, R. 4048); a grievance committee also was appointed in 1948 (Gov. Ex. 794, R. 4081); the year in which this action was brought. The latter committee in 1948 served upon a doctor a notice of the type that had been used previously to initiate disciplinary proceedings, asking the doctor to appear before it and explain his contract practice with the Eagles (Gov. Ex. 1894, R. 5607; cf. Gov. Exs. 875, R. 4232; 1067, R. 4467).[53]

The only disciplinary proceedings held from

[52] Weston then entered the general insurance business, writing insurance, including medical indemnity policies, with leading companies (R. 689, 692).

[53] This doctor met with the Grievance Committee and discussed the relation of various aspects of the Eagles' medical plan to the Principles of Medical Ethics (R. 778, 779). As a result of this discussion he removed from the cover of a booklet given to Eagles members the names of the Aerie physicians

1936 to the time of trial involved hospital association or fraternal organization practice (R. 1769).[54]

e. Boycott

The district court found: That there is no present conspiracy, combination, agreement or concert of action among doctors not to take tickets of, or accept payment from, privately owned hospital associations; that such associations have not insisted or requested that doctors take tickets; that under the contracts and the practice of such associations, the doctor has cooperated with the association if patients receive itemized statements of services rendered; that refusal of doctors to take tickets of or accept payment from privately owned associations is not boycott (Fdg. 46, R. 2028); that if some or all the defendants at any time boycotted such associations, none of the defendants had done so in recent times; that none of the defendants has any intention to boycott such associations in the future (Fdg. 47, R. 2028);

(R. 787), to "correct any implication that we were running a panel medical service" (R. 781). The Multnomah Society Council was informed that the Grievance Committee had concluded that "certain features" of the Eagles' contract practice were in violation of the Principles of Medical Ethics, and that the chief aerie physician "was given a limited time to make the adjustments which are necessary" (Gov. Ex. 795, R. 4084).

[54] For an outline of the evidence as to the restraint of trade and monopoly purposes of the disciplinary proceedings and, indeed, of the boycott next to be described, see *supra*, pp. 36–41.

that prior to 1941 some of the defendants advised doctors not to cooperate with commercial prepaid medical care organizations in certain practices engaged in by them; that such action was not the result of any conspiracy to restrain or monopolize the prepaid medical care business, but was for the purpose of maintaining the standards of medical practice among medical society members (Fdg. 22, R. 2022–3).

The uncontradicted evidence is that: In Oregon, most prepaid medical care plans involve a system known as "taking tickets." Both the hospital associations and OPS use this method (Gov. Exs. 71, R. 2178; 99–100, R. 2261–4; R. 425, 466). A subscriber under the plan presents a "ticket" or, in the case of OPS, a "treatment requisition" to the doctor (Gov. Ex. 169, R. 2533). The doctor, in turn, submits a report to the association on services rendered, and the association pays him according to the fee schedule.[55] Such reports are necessary for the associations to determine their liability (Gov. Ex. 848, R. 4192; R. 435).

Prior to 1936, sales representatives of the hospital associations had found Oregon doctors friendly and cooperative (R. 532). With the development of this conspiracy, however, the situation changed. The 1936 policy statement of the

[55] Doctors having an appreciable amount of association business generally submit monthly reports and receive monthly settlements (R. 808, cf. Gov. Exs. 2205, R. 6631; 2212, R. 6691).

Council of the State Society, published in the Medical Reporter and sent to every member of the society, described as an "entirely sound" solution to the "abolition of the unethical practices of the commercial associations" the action of one local society in "acting as a unit in serving notice upon these associations that they will not attend the patients of these organizations who have been obtained by unethical practices." (Gov. Ex. 662, R. 3693.)

Under the new policy, doctors, and sometimes hospitals,[56] refused to "take tickets"; *i. e.*, they declined to look to the hospital association for payment of bills. Instead, the subscriber was treated as a private patient. Hence the patient, despite his coverage under the medical care plan, was required to pay the doctor for the services rendered. In some instances payment was delayed until the patient obtained the money from the association; in other instances he had to pay immediately and then obtain reimbursement from the association. This has led to disappointment, annoyance, and work for the patient (Gov. Exs. 11, R. 2121; 12, R. 2122; 1242, R. 4767; R. 668–70), and additional clerical and administrative details for the associations (R. 383–4, 538–40, 570–1, 808–9) and the employers (R. 717, 730–1, 848). Employees compelled to pay medical bills

[56] The efforts of the appellees to induce hospitals to aid in their war against the hospital associations is detailed *infra*, pp. 69–74.

out of their pockets sometimes could not afford the unexpected cash outlays (Gov. Ex. 42, R. 2153; R. 894–5). This was particularly significant where hospitals refused to accept association tickets for their often substantial bills (Gov. Ex. 1335, R. 4931).

Not only have Oregon doctors refused to "take tickets," but they have declined to furnish the associations, and, in some instances, patients, with itemized statements of services rendered; they have also refused to make reports to the associations,[57] or to accept association checks made out directly to them or to the patient and endorsed by the latter.[58]

A 1940 policy statement described it as "contrary to the best interests of the public and the medical profession" for Medical Society members to associate themselves "directly or indirectly" with "any special plan of medical care which has not been submitted to and approved by the Council." The statement enunciated the following policy with respect to the ethical standards of members "serving subscribers of unapproved hospital associations and similar organizations" (Gov. Ex. 343, R. 3166):

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[57] Gov. Exs. 11, R. 2121; 16, R. 2127; 17, R. 2128, 40, R. 2150; 42, R. 2153; 47, R. 2156; 48, R. 2156; 54, R. 2160. For the difficulties National Hospital Association had because of appellee Leitch's refusal to give an itemized statement to a patient, see Gov. Ex. 1778, R. 5394.

[58] Gov. Exs. 12–14, R. 2122–25; 35, R. 2142; 44, R. 2154; 49–53, R. 2157–60; 56, R. 2162; 61, R. 2163; 68, R. 2172.

1. The following conduct of physicians may be regarded by the disciplinary bodies of the local medical societies as some evidence of association with unapproved organizations or organizations engaged in unethical practices:

(a) Accepting tickets of such organizations.

(b) Billing such organizations directly.

(c) Accepting payment directly on the organization's fee schedule, including accepting checks from such organizations, or checks of such organizations endorsed by the patient.

(d) Rendering reports to such associations concerning conditions of the physician's patient.

(e) Becoming one of a limited panel of physicians at the call of such organizations.

(f) Any other conduct indicating association with such organizations.

2. Merely performing medical service for a patient who happens to be covered by a contract of an unapproved hospital association or similar organization is not in itself sufficient evidence of association of physicians with such associations or organizations, provided the entire dealing and conduct of the physician shows the normal relationship of physician and patient.

In the June 1944 issue of Northwest Medicine, doctors were urged to scrutinize carefully reports requested by hospital associations and to ignore

or refuse them "if at all off-color."[59] (Gov. Ex. 714, R. 3901.) In 1945, doctors were urged to follow the private patient policy, described as "long * * * established and operative in dealing with those who have some sort of contract with commercial hospital associations," in handling industrial and railroad contract cases (Gov. Ex. 716, R. 3906.)

A restatement of the "Private Patient Policy" for doctors "recently returned from service" in the April 1946 issue of Northwest Medicine classified contract cases on an ethical basis. Commercial hospital associations were in the last category among "the rest of the cats and dogs."[60]

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[59] The same article suggested that when a patient presented a ticket "time should be taken out" to explain that the doctor's concern and contract were with the patient alone, and that the intrusion of any third person would be without the doctor's knowledge or consent and therefore "unacceptable and obnoxious to him as a doctor, in addition to being totally unnecessary. No charge should be made for the time spent with the patient in having him understand the doctor's position clearly, although it may interfere with other demands of practice. It should be considered a small contribution to better public relations and the protection of a grand profession against its enemies without and within." (Gov. Ex. 714, R. 3901.)

[60] It said:

"These 'third-rate coverage' cases have some kind of evidence (usually a 'ticket' or some identification), or a story, indicating they may have some form of financial arrangement with some commercial firm. * * *

"To avoid the questionable medical contracts of one sort and another falling into the third category mentioned above, there is one definitely safe procedure which is being followed more and more throughout the state. *All patients falling*

(Gov. Ex. 718, R. 3912.) The restatement referred (R. 3914) to the "exploiters of the profession" who had relied upon the "collossal avarice of certain short-sighted doctors to continue selling the profession down the river of cut-rate medicine, while the exploiters enjoy a huge belly laugh and prosper."

The article advised the returning doctors to see individuals covered by such plans as private patients, and pointed out to them that when treating a private patient they were under "no obligation whatever to make any kind of a report to any third party upon the condition of his patient." It suggested that the "private patient policy" might prove a "surprise" to "those avaricious individuals who are busily prostituting their services for a dollar in hand." (*Ibid.*, R. 3914.) Dr. Panchen, a young doctor recently returned from service who had joined the State Society and OPS, refused to accept a National check in the spring of 1946 or 1947, although at that time he had had no experience with hospital associations (R. 1258–1259). He refused to take it because "My union has told me that I can't take those checks" (R. 765).[61]

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into the third class are seen strictly as private patients. This enables the ethical doctor to render the medical services sought without becoming involved in any way with the questionable end of the matter, and without becoming an unfair competitor to his colleagues." (Gov. Ex. 718, R. 3913.)

[61] The doctor testified that he did not "recall saying that" (R. 1255), but admitted it was "possible" that he might have (R. 1258).

In October 1946, Northwest Medicine, in describing a new fee schedule offered by "some commercial interests conducting a profitable brokerage of private medical services," urged doctors not to "sell themselves and their colleagues into bondage" (Gov. Ex. 2220, R. 6725–6, italics added):

> There has never been noted any effort on the part of the commercials to do anything toward warding off the threat of politicalized medicine. By contrast, the presence of voluntary prepayment medical service plans sponsored by the profession, with all the risks and advantages that such sponsorship entails, has been and continues to be one of the prime rocks likely to defeat the ill-advised hopes of the central planners. Under these circumstances and with the certainty that threats of politicalized medicine will increase in the next congress, *it is doubtful if any doctor worthy of the name will give the slightest response to the luring appeals of the commercial interests.* On the contrary, his thoughts, actions and efforts should if anything be redoubled to make the profession's own programs work, even if this entails considerable temporary financial sacrifice in the doing.

In 1947, the Council of the State Society approved a recommendation that the Oregon State Industrial Accident Commission should not let

medical care contracts to hospital associations (Gov. Ex. 371, R. 3241).[62]

The State Society supported and encouraged the county societies in carrying out the boycott of the hospital associations by the Oregon organized medical profession. The two groups worked together. The county societies frequently turned to the State Society for guidance. Proposed communications, publications and by-laws were submitted by the county societies to the State Society's legal counsel for approval or were drafted by him in the first place (Gov. Exs. 924, R. 4307; 925, R. 4308; 1200, R. 4722; 2012, R. 6129). Doctors frequently referred to the attitude of the medical societies in communications relating to their participation in the boycott.[63]

For example, one Portland doctor, in a 1946 letter to a patient diagnosing the latter's illness so that the patient could obtain reimbursement from National, stated that: "members of the

[62] For a similar attitude expressed by one of the local societies in 1940, see Gov. Ex. 1234, R. 7547–8.

[63] Member doctors of the medical society appellees advised not only their patients of the existence of a boycott of the hospital associations (*e. g.*, Gov. Exs. 11, R. 2121; 12, R. 2122; 14, R. 2125; 16, R. 2127; 40, R. 2150; 47, R. 2156; 49, R. 2157) but also business concerns (*e. g.*, Gov. Exs. 10, R. 2121; 13, R. 2123; 26–31, R. 2135–8), the State Industrial Accident Commission (*e. g.*, Gov. Exs. 1355, I. 4948; 1369, R. 4961), and a hospital association (*e. g.*, Gov. Exs. 18–21, R. 2129–31; 25, R. 2135; 33, R. 2140; 35, R. 2142; 43, R. 2154; 44, R. 2154; 45, R. 2155; 51, R. 2158)

Medical Society are not allowed to make direct reports to * * * [the hospital associations] or to receive remuneration from them directly;" (Gov. Ex. 16, R. 2127). Another doctor wrote to Industrial in April 1948 as follows (Gov. Ex. 601, R. 2148–9, italics added):

> It has come to my attention that we physicians in this office are practicing contrary to the rulings of the City and County Medical Society, and the State Medical Society, by accepting patients from hospital associations, and especially accepting checks. It follows then that *if I am to maintain my membership in the City and County, State, and national organizations I shall have to discontinue this practice,* and henceforth accept patients only on a private basis.
>
> I have decided therefore that, until the medical profession becomes broad enough to get along together and integrate themselves into a single group for the betterment of the health of the country, as well as of their own interests, I shall have to conform. It is not my wish to promote this division of our forces, but until a better solution is reached I shall have to accept patients only on a private basis.[64]

[64] In a letter to National, written in the same month, this doctor stated: "The Medical Society has ruled that members may not accept remuneration from the private hospital associations. To this I shall have to conform, even though I feel that it will tend in many cases to hinder rather than to promote a free choice of physicians." (Gov. Ex. 39, R. 2146.)

The boycott began in different areas at different times. In some counties it commenced as early as 1938.[65] In Washington County, on the other hand, it was not instituted until 1942 (Gov. Exs. 606, R. 3640; 609–14, R. 3642–5). In many of the counties it was heralded by similar letters written by a number of doctors to employers and hospital associations giving the identical date for stopping hospital association work.[66]

Typical of such letters was the following written by a Washington County physician to an industrial firm in December, 1941 (Gov. Ex. 611, R. 3643):

> Something over a year ago the Oregon State Medical Society went on record as

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For other recent examples of this attitude, see Gov. Exs. 40, R. 2150 ("I am under obligation to not fill out any of their [National] blanks.") (1945); 41, R. 2151 ("Our own organization will not allow us to accept checks from the National Hospital Association.") (1946).

[65] E. g., *Clackamas County:* Gov. Exs. 1429–31, R. 5021–2; 1434–7, R. 5024–6; 1439, R. 5027. *Lane County:* Gov. Exs. 618–630, R. 3648–54.

Although a number of appellees' witnesses testified as to why they had ceased dealing with the hospital associations, none indicated that he had done so before 1936 when this conspiracy was formed. Furthermore, there is no evidence in the record of any boycott prior to that time. The record also shows that the boycott continued in some counties even after the complaint had been filed in this case (Gov. Ex. 68, R. 2172; R. 1801), and as late as 1949 (R. 859, 1792–3, 1796, 1801).

[66] Among such letters were those written by a group of Columbia County doctors in July 1938, notifying the Pumphrey Company that they would not do any work for it after August 10 (Gov. Ex. 1056, R. 4431).

> looking with disfavor on contract practice. In fact, they went so far as to threaten expulsion from the state society, a step we all would hate to see taken. Until we had something else to offer we hesitated about taking steps to conform with the state society ruling. However, now we feel that we have such facilities for taking care of this contract work and we feel that we must conform with the state society ruling.
>
> Therefore, this will serve as our notice that on and after February 1st, 1942 we will not serve any treatment orders from any hospital association that is not recognized by the State Medical Society.

Another Washington County doctor wrote (Gov. Ex. 610, R. 3642):

> More than one year ago action was taken by the Oregon State Medical Society condemning those Physicians who service contracts issued by any Hospital Association other than those recommended by the Society.
>
> In conformity with this policy, after February 1st, 1942, I will service only tickets issued by the Washington County Division of the Multnomah Hospital Association, or other Physician owned Hospital Associations.

An example of the form the boycott took is what happened in Lane County. Following passage of a motion by the local medical society that its members would discontinue work for "un-

ethical associations" after January 1, 1938 (Gov. Exs. 1009–10, R. 4391), fifteen Lane County doctors notified both Industrial and National Hospital Association that they would not treat patients under their contracts after January 1, 1938.[67] Some of these letters were worded identically (e. g. Gov. Exs. 623 and 624, R. 3651), and some were written by doctors who had done little or no business with the associations in 1937 (Gov. Exs. 1369, R. 4959; 1393, R. 4990; 1394, R. 4991). Among the doctors was appellee Hunt (Gov. Exs. 1411, R. 5004; 2069, R. 6394), who had never treated any hospital association patients (R. 1475).

In the following years, letters from Lane County doctors returning hospital association checks frequently referred to medical society policy as the reason for their action.[68] The Lane

[67] *Industrial*: Gov. Exs. 618–630, R. 3648–54; 2069, R. 6394. *National*: Gov. Exs. 1369, R. 4958; 1393, R. 4990; 1394, R. 4991; 1399–1403, R. 4995–99; 1410, R. 5003; 1411, R. 5004.

At the same time, the Lane County Society also requested a ruling from the State Society on whether it was unethical for a physician to treat a patient and receive the customary fee when he knew that the patient was receiving the money to pay the fee from an unethical association (Gov. Ex. 318, R. 3070). The executive committee of the Council of the State Society actually recommended that such practice be ruled unethical. The recommendation was tabled (Gov. Ex. 329, R. 3107).

[68] A letter from a Lane County doctor in October 1938, returning a Prudential check, stated: "According to the ruling of the Lane County Medical Society, no physician is sup-

County Society also reiterated its policy of boycott. At the January 20, 1939, meeting of the society, it was voted that members of the society should not cash or endorse checks of "unauthorized" hospital associations, or give patients under such hospital association contracts information concerning diagnosis or treatment that could be transmitted to the association (Gov. Ex. 1014, R. 4394).[69] In 1949, the society passed a motion "that no member of the society shall knowingly treat any patient covered under contract by an unapproved Hosp. Assoc. except in case of acute emergency *regardless of whether he pays the bill*

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posed to accept these contract cases" (Gov. Ex. 855, R. 4207). Another Lane County doctor, in returning a National check in 1939, wrote: "I cannot stay in good standing with my medical society if I accept checks from you" (Gov. Ex. 1322, R. 4923); still another stated that "by the rules of the Lane Co. Medical Society we cannot accept checks from the association, but receive pay from the patient direct" (Gov. Ex. 1442, R. 5029).

In 1940 a Lane County doctor told National that: "The Medical Society has simply issued what practically amounts to an ultimatum that its members can no longer accept checks directly from your Association without being expelled from membership" (Gov. Ex. 44, R. 2155).

[69] This action should be contrasted with finding 27 (R. 2023) that "*None* of the defendants has * * * encouraged other doctors to refuse * * * to give patients itemized statements to enable the patients to be reimbursed under any plan of prepaid medical care" (italics supplied).

The meeting also endorsed the appointment of a "secret committee" by the society's president "for investigation of refractions [sic] of the rules governing the care of patient under contract by unauthorized Hosp. Assoc." (Gov. Ex. 1014, R. 4394.)

as a private patient" (Gov. Ex. 1020, R. 4399, italics added).

A similar pattern occurred in Jackson County. In December 1938, a number of doctors there informed the State Industrial Commission, Industrial, and National that they would not treat cases for hospital associations after the end of the year.[70] Thirteen doctors so wrote to the State Commission (Gov. Ex. 1380, R. 4972), twelve to Industrial (Gov. Exs. 537, R. 3599; 539–48, R. 3599–3604), and seventeen to National (Gov. Exs. 1348–63, R. 4945–53; 1381, R. 4973).

In 1940, members of the Jackson County Society passed a resolution "That the boycott of the National and Industrial Hospital Associations by our member-physicians be discontinued," and that henceforth each physician "should be allowed to determine for himself whether or not his interpretation of the Code of Ethics allows him to work for the lay hospital associations" (Def. Ex. 2701, R. 6976). However, the organized boycott in Jackson County has continued. In 1947, a Jackson County doctor advised National that "In compliance with the policy established by the Jackson County Medical Society" he was "not in

[70] They wrote these letters after the Jackson County Medical Society had forwarded to the State Society a draft of a proposed resolution announcing the severance by its members of all connections with lay-owned hospital associations (Gov. Ex. 951, R. 4330), and the State Society had approved the substance of the resolution (Gov. Ex. 316, R. 3064).

a position" to accept payments directly from National (Gov. Ex. 53, R. 2160). In the month following the filing of the Government's complaint in this suit, a Jackson County doctor wrote to National (Gov. Ex. 68, R. 2172):

> In conformity with the Jackson County Medical Association we are herewith returning National Hospital Association check number 8408 for $9.00. Please arrange for payment of this bill the same as you do for other Doctors who are members of the Jackson County Medical Association.

The foregoing descriptions of what happened in Lane and Jackson Counties are merely illustrative, not exhaustive. The pattern was repeated, in varying degrees, in most of the counties.[11] For example, a Clatsop County physician returned a National check in 1947 with the comment (Gov. Ex. 52, R. 2159):

> Due to a ruling of the Clatsop County Medical Association no doctor can accept checks from your company.

In 1947, a member of the Douglas County Medical Society stated that—

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[11] There was uncontradicted testimony of the existence of boycott since 1941 in Clackamas County (R. 431–2, 724–5), in Clatsop County (R. 695–6, 698, 729–30, 762–3, 766–7, 773, 776, 799–800, 851–2, 854, 892), in Columbia County (R. 433, 734–5), in Douglas County (R. 433, 710–11, 717, 790, 870, 887, 894–5), in Jackson County (R. 543–4, 553–5, 738–9, 897), in Marion County (R. 434, 574), in Multnomah County (R. 434, 574), and in other parts of Oregon (R. 695–6, 831, 881).

> It is a rule of the Douglas County Medical Society that ~~it's~~ practicing physicians do not do any business with National Hospital Association [Gov. Ex. 10, R. 2121].

In December, 1949, a doctor in Multnomah County wrote National the following explanation of why he was no longer taking its tickets (Gov. Ex. 2125, R. 6489):

> I have just recently been aware that my business office has been accepting billings directly from the Association. I am sure you are aware of the situation that exists between the Medical Society and the various insurance groups and, right or wrong, that relationship must depend on a decision between them and the Medical Society.[72]

* * * * *

As a direct result of the boycott, at least thirty identifiable accounts in at least 8 counties were lost by the hospital associations.[73] More than 15 have been lost since 1945[74] and some of these were

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[72] In 1946, the Portland Clinic, comprising a substantial number of doctors, wrote to a patient (Gov. Ex. 17, R. 2128): "We are not connected in any way with the National Hospital Association and because of a ruling by the Medical Society are not permitted to fill out their blanks."

[73] Gov. Exs. 15, R. 2126; 524, R. 3588; 631, R. 3655; 639, R. 3658; 640, R. 3659; 651, R. 3674; 652, R. 3676; 654, R. 3676; 659, R. 3682; 874, R. 4232; 1239, R. 4762; 1241, R. 4765; 1245, R. 4771; 1376–9, R. 4968–70; 1384, R. 4976; 1387, R. 4977; 1458, R. 5062; R. 439, 440, 475, 507, 509, 511, 512, 513, 574, 583, 773–4, 776, 790–1, 831, 894–5, 897.

[74] Gov. Exs. 15, R. 2126; 651, R. 3674; 652, R. 3676; 654, R. 3676; 659, R. 3682; 874, R. 4232; 1384, R. 4976; 1387, R.

lost by Industrial, National, or Prudential directly to OPS.[75] All of such changes in coverage have been made because of the doctors' boycott of the hospital associations. For example, one firm shifted from National to OPS in 1946 "Due to the reluctance and inconvenience of the doctors in refusing to accept the hospital [association] slips" (R. 897). Another company changed from Industrial to OPS in the same year because (R. 894–5):

> The doctors refused to take tickets, and then we couldn't get itemized statements out of them. There was just one jangle after another, so the sawmill men like that don't have money to pay a doctor when they go up there, and they would not take the tickets, so they took the line of least resistance and toook OPS, so if they did not have any money they would accept tickets and go merrily on their way.

Still another shifted coverage from Prudential to OPS in 1947 or thereafter because "We had many complaints from our employees that doctors would not accept the tickets which were issued" (R. 776).[76]

4977; 1458, R. 5062; R. 440, 574, 583; 773–4; 776, 790–1, 831, 894–5, 897.

[75] *E. g.*, R. 773–4, 776, 790–1, 831, 894–5, 897.

[76] A 1948 letter by the general manager of Industrial Hospital Association to a customer did state that "in recent years, this whole boycott business has apparently begun to fall apart because of its own weight" though it went on to note that this was despite "so much O. P. S. poison" (Def. Ex. 2737, R. 7040–41).

f. Attempts to control hospital relations with doctors and members of unapproved prepaid medical care organizations

The district court found: That there has been no conspiracy, agreement, combination, or concert of action among appellees to restrict the use of hospital facilities by doctors cooperating with prepaid medical care plans not sponsored or approved by appellees, or to prevent Oregon hospitals from allowing their facilities to be used by doctors associated with such plans (Fdg. 21, R. 2021); that none of the appellees has conspired, combined, or attempted to limit hospital facilities to medical society members (Fdg. 31, R. 2024); that members of appellee societies have sought to prevent the use of hospital facilities by other doctors, but only in cases of lawful and legitimate professional discipline (*ibid.*); that none of the appellees at any time had interfered with or attempted or combined to interfere with commercial prepaid medical care organizations in obtaining hospital facilities for their members (Fdg. 25, R. 2022).[77]

[77] The court also found that "none of the defendants in any manner restrained hospitals or hospital services or the opportunities of doctors or of patients to obtain hospital services" (Fdg. 48, R. 2028–9). We believe that the relief we are seeking would be justified by a reversal of the findings relating to hospitals that are set out in the text. If Finding 48 is merely duplicative of those other findings, we challenge it only to the extent necessary to avoid any inconsistency between it standing and the others overturned. However, if by "restraints" the court had reference to actual refusals

The uncontradicted evidence is that: Following announcement in October 1935 by the Council of the Multnomah County Society that one of the functions of its Subcommittee on Relations with Hospitals was "To procure the adoption by the hospitals of membership in the Multnomah County Medical Society as one requirement for staff membership" (Gov. Ex. 1995, R. 6095), the Society, in 1936, approved the Martzloff Report, recommending that hospitals be "requested" to make membership in the society "one of the requirements" for staff membership (Gov. Ex. 209, R. 2575). In the same year, the State Society adopted a report on hospitals suggesting that "The importance of requiring membership in the local medical society as a prerequisite to membership on a hospital staff should be constantly stressed." (Gov. Exs. 276, R. 2839; 277, R. 2845.) It also submitted to the American Medical Association House of Delegates a resolution, subsequently passed by the latter (Gov. Ex. 276, R. 2820), recommending that, prior to approval of hospitals, the AMA's Council on Medical Education and Hospitals assure itself that every staff member of such hospital "is conducting his practice in accordance with the Principles of Medical Ethics * * *" (Gov. Ex. 276, R. 2825). Appellee Fitzgibbon advised the State Society that the Judicial Council of

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to admit patients covered by hospital associations apart from the question of financial coverage, we do not except to it.

AMA had called to the attention of all approved hospitals AMA's resolution that the staff of hospitals approved for interne training "should be limited to members in good standing of their local County Medical Societies" (Gov. Ex. 276, R. 2824).

Vanport Hospital, during the period operated by OPS,[78] limited staff privileges to OPS doctors (Gov. Ex. 818, R. 4126). A 1944 article in Northwest Medicine condemned hospitals for giving staff privileges to doctors allegedly not eligible for membership in their local medical society (Gov. Ex. 692, R. 3836–7).

Dr. Suckow, who had resigned from the Multnomah County Society in 1936 after the Board of Censors had recommended his expulsion, was readmitted to the Society in 1945 after he had ceased his hospital association work (see p. 48, *supra*). When he applied for staff privileges at St. Vincent's hospital, the following letter was sent to appellee Fitzgibbon and endorsed by him (Gov. Ex. 1677, R. 5322):

DECEMBER 22, 1945.

Dr. T. M. JOYCE
Dr. JOHN FITZGIBBON

DEAR TOM AND FITZ: Suckow worked for the National Hospital Association for several years. My understanding is that he was forced to do it in order to meet his financial obligations which were heavier

[78] It was taken over by the Permanente Foundation in 1947 (Gov. Ex. 2104, R. 6153; R. 745).

than those of the average physician with his experience at that time.

Several months ago in making application for reinstatement of membership in the County Society, he repudiated this type of practice. He said he would never again engage in it and expressed his intention to do clean, ethical medical work. In view of his sincere act of contrition and firm purpose of amendment, I would be in favor of appointing him on the courtesy staff and give his morale the boost which it deserves. It should be understood of course that he is not to attempt to do any major surgery.

Very sincerely,

/s/ BILL

WILLIAM A. SHEA, M. D.

WAS/e

1/11/46. I feel that Suckow should be given a break and will vote for membership on the courtesy staff with limitations.

(Signed) FITZ

Oregon hospitals themselves participated in the boycott. On January 19, 1940, four hospitals in Coos and Curry Counties sent the following letter to the commercial hospital associations (Gov. Ex. 20, R. 2130):

This letter is to notify you and your Association that beginning the 1st of March, 1940, the undersigned physicians and the Hospitals that they represent will no longer accept National Hospital tickets.

As you know, the physicians in Coquille now have a hospital association—which—

with the Coos bay and Mast Associations we feel is capable of serving their own communities in Coos County.

This action is in compliance with the standards governing contract practice as recently set forth by the State Medical Association, whereby it is considered against the best interests of the patient to have a third party (that is a layman) come between the physician and his patient. Hereafter, only the Hospital Associations owned and operated by physicians will be acceptable by us.

In response to a query from National Hospital Association, the Coquille Hospital in Coquille repiled (Gov. Ex. 25, R. 2135, italics added):

> In reply to your letter of March 13, 1940. *The reason for our refusing to accept tickets issued by the National Hospital Association is based purely upon the policy of the Medical Economics Bureau of the Oregon State Medical Society.* If your association was acceptable to the standards of that committee there will be no question about refusing services to your members. Our policy is in no way based on our past cordial relations and it is with sincere regret that it was necessary for us to take this step.

In February 1942, the Sacred Heart General Hospital sent identical letters to four employers as follows (Gov. Exs. 1332–4, R. 4929–31; 1339, R. 4935):

> We are writing to inform you that in the future it will be impossible to accept patients under the National Hospital Association.
>
> However, we want you to understand that the patients will be accepted, but as private cases, to be responsible for their own accounts.[79]

In August 1949, a Klamath Falls subscriber cancelled her individual contract with National "because the local hospitals will not accept your plan" (Gov. Ex. 1788, R. 5404).

On one occasion appellee Hunt informed the State Society Council that the Lane County Society was trying to obtain "the cooperation of the hospitals in refusing to provide service to the patients of lay-owned hospital associations" (Gov. Ex. 702, R. 3869).

g. Actions against medical care plans operated by fraternal organizations

The Eagles, a fraternal organization, have provided medical care for their membership through a system of organization physicians (R. 781) from whom members could receive medical care without charge (Gov. Exs. 1253–4, R. 4779–82). Prior to 1939, the larger individual chapters, or aeries, generally had one or more aerie physicians (R. 786). The Loyal Order of Moose also pro-

[79] As a result of this refusal to accept National tickets, a subscriber had to pay a hospital bill of more than $100 out of his own pocket (Gov. Ex. 1312, R. 4910; *cf.* Gov. Ex. 1287, R. 4897).

vided medical services for its membership under a similar arrangement (Gov. Ex. 2014, R. 6134).

After the Lane County Medical Society had adopted a resolution in April 1937, declaring that work done for fraternal organizations came within a previous resolution condemning affiliation with "unethical" hospital associations and would be cause for expulsion (Gov. Ex. 1005, R. 4388), the society persuaded one of its members to terminate his contract with the Eagles upon the assurance of the Council that no other member "can take over these contracts and retain their membership in the Society" (Gov. Exs. 1006–1007, R. 4389–90).[80] At the same time, an-

[80] The minutes of the Council report (Gov. Ex. 1006, R. 4389):

> It is moved, seconded, and passed that Dr. Edblom be called before the council to discuss his contract with the Eagles Lodge.
>
> The secretary was instructed to contact Dr. Edblom immediately.
>
> This was done by telephone. Dr. Edblom stated to the secretary that he was unable to be present at the meeting, but he told the secretary that his membership in the Medical Society meant more to him than any medical contract, that he had, and that he was willing to discontinue the contract on receiving a letter from the council to that effect, that this type of practice was unethical, so that he could have something concrete to show to the Eagles officials as to why it was necessary for him to give up his contract with them.
>
> It was moved, seconded, and passed that Dr. Edblom and Dr. Walker be commended on their stand in discontinuing their medical contracts with fraternal organizations and that the Council of the Lane County Medical Society assures them that no other member of

other doctor also resigned as Eagle physician, apparently at the Society's request (Gov. Ex. 2025, R. 6170). A resolution of the Jackson County Medical Society provided that after May 1, 1938, no member of the Society was to be affiliated in relation to the practice of medicine with any fraternal organization (Gov. Ex. 957, R. 4338). In 1939, the State Society condemned as "unethical" the contracts under which the Moose employed lodge physicians (Gov. Ex. 2014, R. 6133). At a 1937 meeting of the State Society Council, it was reported that an effort being made by component societies "to discontinue unethical contract practice carried on through lodge organizations * * * is also being brought to a satisfactory conclusion" (Gov. Ex. 315, R. 3060).

In 1948, preliminary disciplinary proceedings were instituted by the Multnomah County Society relating to one doctor's contract practice with the Eagles (see p. 50, *supra*).

For a number of years the Eagles have discussed, both locally and at state conventions, the difficulties of getting doctors to cooperate with them (R. 786). At the time of the trial, the constitution of the Eagles authorized the local aeries to dispense with the services of an aerie physician whenever it had become impossible to obtain one "by reason of the rules of any medical

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the Lane County Medical Society can take over these contracts and retain their membership in the Society.

society, or * * * for any other reason" (Gov. Ex. 1895, R. 5608).

h. The campaign against industrial contract practice

Railroad contract practice was condemned by the State Society in 1944 and 1945. An editorial in the August 1944 issue of Northwest Medicine described such practice as a "barb in the flesh to the medical profession" and "bordering on the order of prostitution of a noble calling." It urged that doctors engaged in such practice should be enlightened "as to the economic facts and other factors involved," and suggested that if such effort failed, those doctors were "certainly no longer entitled to any further consideration on the part of regular men of medicine." (Gov. Ex. 691, R. 3828, 3830–1.) The editorial concluded that if railroad employees could be persuaded to use their personal physicians for medical care, it would "probably not be at the same cut-rate cost heretofore enjoyed by railroads and railroad employees at the expense of the medical profession" (*ibid.*, R. 3822).

A 1945 article stated that there was "precious little difference" between hospital association and industrial contract practice. It referred to the "simpleton nature" of doctors who "succumb to the lure" of the latter (Gov. Ex. 697, R. 3847). It noted that the councils of a number of county societies were "looking into the relationships of their members with increasingly critical eyes".

It was intimated that there might be further action "where educational efforts alone may prove insufficient." (*Ibid.*, R. 3847–8.) In 1945 the House of Delegates, in extending the "private patient policy" to railroad and industrial contract practice, suggested that "there should be no occasion for doctors to fail to follow this policy in their own professional and financial interest. If there are any such instances other remedies may be applied" (Gov. Ex. 716, R. 3907). It was pointed out that, "There is nothing new in this policy. It has long been established and operative in dealing with those who have some sort of contract with commercial hospital associations" (*ibid.*, R. 3906).

When employees of the Pacific Telephone and Telegraph Company organized a statewide prepaid medical care plan for themselves and their dependents in December 1944, Northwest Medicine said the proposal "heaved a weighted club" at Oregon's medical profession by "going over the heads of regular medical organizations, including the Oregon State Medical Society and Oregon Physicians' Service" in appealing directly to the doctors to participate in the program (Gov. Ex. 697, R. 3844–5). It suggested that the employees' letter addressed to all Oregon doctors seeking their participation in the plan could have been better worded to read "somewhat as follows" (*ibid.*, R. 3845):

> Greetings, Suckers! The telephone [illegible] cut-rate medical care on

> a prepaid basis, so we have organized our own hospital association for employees leaving the boss out to get this regardless, including drugs and family coverage. We are a preferred health group, therefore should get a low cost rate, and we think $1.75 to $2.00 is about right, including the drugs handout. We've checked this with some of our pal doctors who are sharper than your medical society dummies and accordingly we send you herewith the fee schedule which will govern the activity. Whether you like this fee schedule or not, it is our baby and will be the remuneration while you serve us, but we will pay off by the tenth of each month. We hope you will approve this set-up and fall in line with our ideas, so to make your submission easier we enclose herewith a stamped addressed envelope for your anticipated favorable reply.

"This is a definite crisis in the affairs of Oregon's doctors," Northwest Medicine reported, "a bold attempt to foist cut-rate medical care upon them and their patients under the guise of a poorly conceived prepaid plan. This and all other similar bludgeoning efforts should well receive from each doctor of the state the treatment it so richly deserves" (*ibid.*, R. 3847). Doctors who participated in the plan were described in 1947 as "selling both themselves and their colleagues down the river of cut-rate medicine to ultimate disaster" (Gov. Ex. 807, pp. 302–3, not printed).

i. Other actions against non-medical society sponsored prepaid medical care plans

In the fall of 1946, a group in the farming area near McMinnville, Oregon, became interested in organizing a cooperative group health plan (R. 833). The group discussed the matter with one local doctor who appeared interested (R. 833–4). However, he subsequently informed the group that he could not serve it because it would strain his relations with his fellow doctors (R. 834–5, 842). Other doctors were consulted (R. 835), and, in 1947, the group sought to acquire a hospital in the area (R. 835). Dr. Huckleberry, the majority stockholder in one of the local hospitals, indicated his willingness to sell his interest (Gov. Ex. 1939, R. 5849; R. 835–6).

Members of the local medical society discussed the proposed cooperative plan with the State Society Council (Gov. Ex. 382, R. 3290; R. 837). A meeting was then held between the group and the county Society. The group was unable to reach an agreement with the doctors on the terms of the proposed plan, the doctors urging the group to take OPS coverage. (R. 839–40, 845.)

Subsequently, Dr. Huckleberry informed the group that he was not interested in selling the hospital to them. He stated that he had seen the executive secretary of the State Society and that the latter had pounded on the table and told him that before he sold the hospital to the cooperative group he had better get a plan that

was acceptable to the doctors[81] (R. 841). Nothing ever came of the cooperative plan (R. 841), and Dr. Huckleberry sold his interest in the hospital to someone else (R. 845).

The Permanente Foundation was organized during the war by Henry J. Kaiser to provide medical service for shipyard workers and their families through offices and a hospital in Vancouver, Washington (R. 744–5). Since the war, operating as a partnership among a number of doctors (R. 745, 750, 755–6), it has offered prepaid medical care to the general public and has added a clinic in Portland, Oregon (R. 744–5).

In 1946, an article in the Multnomah County Society Bulletin attacked the Foundation and urged its doctors to enter practice in Portland as OPS participating physicians (Gov. Ex. 2179, R. 6568). Dr. Ullman, who before the war had been affiliated with OPS (R. 742), sought to reestablish his connection after discharge from the service. He was given a "hearty welcome" by OPS officials until he stated that his office was with the Foundation. He was then told that under the circumstances he could not rejoin OPS (R. 743–4), even though at that time he was a member of the state medical society (R. 742).[82]

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[81] The executive secretary, who testified twice after this testimony concerning Dr. Huckleberry had been given, did not deny such action.

[82] One of the OPS officials who had spoken to the doctor, a witness for appellees, testified that he had not told the doctor that the latter could not be an OPS cooperating physician

In 1947, OPS refused to authorize treatment of students under an OPS contract at the Permanente hospital on the ground that OPS participation was limited to members of the state and/or component medical societies (Gov. Exs. 440, R. 3414; 441, R. 3415). The Foundation then requested the Committee to give OPS staff membership status to two Permanente doctors who were members of the Multnomah County Society (Gov. Ex. 842, R. 4177–8). No action was taken on this request (Gov. Exs. 793, R. 4077; 794, R. 4080). Similarly, applications for membership in the Multnomah County Society filed by three Permanente doctors in 1948 and 1949 were never acted upon (R. 746, 749, 1519–20).[82a]

5. APPELLEES' EFFORTS TO LIMIT COMPETITION AMONG, AND THE MEDICAL CARE TO BE PROVIDED THROUGH, MEDICAL SOCIETY SPONSORED PLANS

By 1939, there were seven local medical society sponsored plans operating in 13 counties (Gov. Exs. 65, R. 2166; 1427, R. 5019; R. 503). Under many such plans, the participating physicians had agreed not to do any work for the commercial hospital associations (see p. 40, *supra*).

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because he was connected with Permanente (R. 1665). On cross-examination, however, he stated that although he remembered conversing briefly with the doctor, he had no distinct recollection of a particular conversation with him (R. 1678), and that it was his custom to inform doctors returning from service that they had to be eligible for medical society membership to join OPS (R. 1678–9).

[82a] In finding 49, however, the district court concluded that "At no time within recent years has the membership in any

The State Society has coordinated the operations of these plans through its Bureau of Medical Economics (Gov. Exs. 65, R. 2166; 1427, R. 5019; R. 503).

a. Allocation of territories

The district court found: that lack of territorial competition among doctor sponsored plans has not been the result of any conspiracy or combination in restraint of trade (Fdg. 30, R. 2039).

The uncontradicted evidence is that: The State Society in 1938 and 1939 enunciated the "principle" that each local plan limit its operations to the territory of the local society by which approved, unless authorized by the Council to extend its coverage into a neighboring county upon the request of the Society or the doctors there (Gov. Exs. 281, R. 2921; 325, R. 3099).

The State Society approved the local plans proposed by the Coos and Curry County Medical Society in 1941 on the "understanding * * * that each of these organizations * * * will limit its activities to a definite geographical area" (Gov. Exs. 680, R. 3802; 2010, R. 6127). While local bureaus have requested and received authority from the State Society to operate beyond their territory (Gov. Exs. 345, R. 3173; 350, R. 3191; 2036, R. 6318), when local groups have complained about "foreign" plans' contracts in their areas, the State Society has taken steps to correct

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medical society been denied to any doctor because of his connection with any private hospital association" (R. 2029).

the situation (Gov. Exs. 1986, R. 6076; 1994, R. 6093).[83]

Oregon Physicians Service itself does not enter any county until prior authorization has been received from the county society (Gov. Ex. 480, R. 3520; R. 1661–2). This is in accordance with the State Society's 1942 announcement to the profession that "Naturally O. P. S. operations will be conducted only by approval of the local medical society in any involved area" (Gov. Ex. 1164, R. 4676).[83a]

OPS has refrained from competition with other medical society sponsored plans. A request for coverage from a group in Clackamas County was turned down, apparently because that was the territory of the local physicians' association (Gov. Ex. 1202, R. 4724). A doctor in Reedsport inquiring about possible coverage in his area was informed that "OPS operates directly in all other counties in the state with the understanding that there will not be any direct

[83] Thus, the State Society aided the Benton County society in 1940 and the Linn County society in 1941, in terminating certain contracts that the Multnomah Medical Service Bureau had written in those counties (Gov. Exs. 1986, R. 6076; 1994, R. 6093).

[83a] The State Society has maintained close supervision over the operations of OPS. It has "approved" OPS contracts prior to their execution (Gov. Exs. 289, R. 2978; 700, R. 3861). Similarly, the local societies were consulted respecting OPS proposals for service in their areas (Gov. Ex. 388, R. 3302), and on occasion have rejected such proposals (Gov. Ex. 1043, R. 4421).

competition with the county plans," and that since his area customarily was serviced through the Coos Bay County Plan, OPS was of the view that "we should not competitively solicit business in that area" (Gov. Ex. 1609, R. 5263).

OPS has extended its operations into the various counties only gradually because of the necessity of getting local approval (Gov. Exs. 391, R. 3307–8; 399, R. 3328; 402–4, R. 3334–8); it did not write contracts in some counties until 1946 (Gov. Ex. 427, R. 3390).[84] Several of the local plans, including the Multnomah County plan, have been merged into OPS (Gov. Exs. 125, R. 2327; 393, R. 3313; 399, R. 3328; 989, R. 4369; R. 1657).

b. Limitations on coverage

In addition to eliminating competition among doctor-sponsored plans, the appellees have limited the availability and scope of the care provided by such plans.

(1) *Income.*—Appellee State Society and several of the appellee county societies have been concerned with limiting the income level of subscribers covered by prepaid medical care plans.[85]

[84] The Columbia County Medical Society authorized OPS to enter Columbia County in 1942 only on condition that existing contracts of Multnomah Medical Service Bureau were not to be disturbed without the Society's consent (Gov. Exs. 485, R. 3528).

[85] Thus, the form adopted by the House of Delegates in October 1936 for State Society members' use contained the statement: "I (we) declare that there are no persons receiving

Coverage of higher income groups, such as school teachers (Gov. Ex. 2025, R. 6165–66), was to be avoided. In November 1939, the following statement was sent by the State Society to local medical societies (Gov. Ex. 672, R. 3767, italics added):

SUBSCRIBER ELIGIBILITY

> Probably the most important feature of plans for the medical care of low-wage industrial groups is the determination of a sound policy with respect to the income level at which subscribers are admitted to the benefits of these plans. The primary purpose of special plans is to afford relief to persons below the "comfort" level standard of income. *Unless definite policies limiting the benefits of special plans to this group are adopted and enforced, the ultimate result will be the gradual expansion of these plans to include almost all classes of the population.*
>
> * * * * *
>
> The responses of organizations conducting prepaid plans of medical care in Oregon and Washington indicated an anarchic situation so far as income levels are concerned. A number of these organizations indicated that they had no income level. Other organizations reported an income level of $1800 or $2400 for both single and married persons, but stated that these levels were not enforced. *The reason almost uni-*

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medical care under this contract whose average monthly wages exceed the sum of $_____" (Gov. Ex. 304, R. 3035).

formly given by these organizations for their failure to adopt or enforce a definite income level was the existence of competition in the local community from groups of non-participating physicians, clinics, or commercial hospital associations, which enforce no income level among employees and frequently include the executives and owners. Local organizations also pointed out that employees in the higher income brackets frequently wielded large influence among their fellow employees and that their exclusion would often result in the rejection of the plan by the employees.

It is recommended that a maximum income level of $1,000 for single persons and of $1,600 for man and wife be adopted as an objective, each local organization to be permitted to fix lower income levels, if it so desires. It is further recommended that when a local organization, because of special local factors, deems it desirable to deviate upward to some extent from these maximum income levels, it be required to present the facts to the Bureau of Medical Economics and the Council and to obtain their prior approval for such deviations; provided that if any emergency with reference to a specific contract presents itself, such approval may be obtained from the Executive Committees of the Bureau and the Council, acting jointly.

It is also recommended that local organizations do not accept owners or managers as subscribers.

A 1937 resolution of the Jackson County Medical Society, approved by the State Society, described prepaid health insurance as "desirable" for low income groups but "vicious in its action" when extended to "highly paid wage earners or employers" (Gov. Ex. 951, R. 4330). In 1939, the Mid-Columbia Medical Society voted not to work for any hospital association whose contracts covered individuals with incomes exceeding $1,000 for a single person and $1,500 for a married person. (Gov. Exs. 1233, R. 4756; 2000, R. 6102). The local groups have sought the State Society's advice on problems of appropriate income limitations. In 1939, the Lane County Medical Society asked the State Society "what is the 'comfort level' of income over which it shall be the policy of our society to not approve plans for prepaid medicine?" (Gov. Ex. 2004, R. 6108).[80]

OPS individual contracts since 1947 have contained a $6,000 net income limitation, Gov. Ex. 1801, R. 155). The 1949 session of the House of Delegates voted to recommend the inclusion of income limitations in all contracts, with a suggested $3,000 limit for commercial coverage (Gov. Ex. 2064, R. 6386).

[80] In 1940, one of the local medical society-sponsored plans informed the State Society that "We feel that to set a wage limit is a step in the wrong direction. It is difficult enough for the Doctor-owned Bureaus to convince a community as a whole of an unselfish aim in the advancement of their function without having information of this kind available from our on [sic] State Medical Society" (Gov. Ex. 1182, R. 4700).

The commercial hospital associations generally have no income limitations in their contracts (e. g., R. 393), although on occasion they were willing to impose such restraints to gain medical society approval (Gov. Exs. 1235, R. 4758; 1236, R. 4759; 2018, R. 6149).

(2) *Family coverage.*—Both the State Society and the county societies have opposed extending prepaid medical care coverage to family groups.[87] Thus, in 1940, the Clatsop County Medical Society indicated its opposition to a family coverage proposal presented for approval by Industrial Hospital Association (Gov. Ex. 923, R. 4307). The Columbia County Medical Society informed the State Society in 1941 that it was "one-hundred percent against sanctioning any family coverage" by the Multnomah doctors' plan, since it would be "a matter of time only" before such coverage on a contract basis would be demanded by plants in Columbia County, and "once this type of contract was established [it] would long survive the duration of the emergency." (Gov. Ex. 2038, R. 6324.)

The minutes of the March 14, 1945, meeting of the Jackson County Medical Society show the following entry (Gov. Ex. 979, R. 4360):

[87] In 1942, Multnomah County Medical Society instructed its Grievance Committee to "investigate the activities of certain members, in association with certain non-members, in offering a plan of prepaid medical service to employee groups and their families in certain industrial plants" (Gov. Ex. 770, R. 4028).

> Hospitalization for families—Blue Cross is selling. Disapproved by house of delegates. Reason—develops increased demand for medical care—we are too busy now. Extension of medical care to all will follow.

Not until 1946 did OPS offer a qualified family coverage (Gov. Ex. 1220, R. 4739; R. 1668); in the previous year, the State Society had voted against OPS providing such a service (Gov. Ex. 980, R. 4362).[88] Before OPS instituted family coverage in any area it had to get the permission of the local medical society (Gov. Exs. 433, R. 3401; 482, R. 3522; 496, R. 3537; 503–4, R. 3548; 932, R. 4313; R. 1686).

(3) *Services provided.*—Since 1938, the organized medical profession in Oregon has sought to

[88] An OPS official, upon his resignation in 1945 (Gov. Ex. 421, R. 3370), made the following comments on this aspect of OPS operations (Gov. Ex. 422, R. 3373):

"Despite repeated demands from the public, no direct action has been taken by management to make any form of family coverage available to existing groups of subscribers * * *. The organization which is O. P. S. can and should be given authority to undertake lines of business which will answer fully the long-established public demand for prepaid medical care. The medical profession cannot claim that O. P. S. fully provides the sort of program demanded by the public because the employed member of the family is the only one reached by O. P. S. at present. O. P. S. therefore is failing the public and is also failing the medical profession by not at least offering some kind of family coverage. While it is a fact that more of the population is covered by prepayment plans here in Oregon than in any other state, family benefits for Oregonians are practically nonexistent * * *."

keep the prepaid medical care business separate from prepaid hospitalization. In that year, the State Society formulated a policy of cooperation with the Oregon Association of Hospitals to develop a plan for prepaid hospitalization "with the ultimate objective of limiting prepaid plans approval by local societies to supplying professional services" (Gov. Ex. 667, R. 3738; 672, R. 3749, 3753). Negotiations were held between representatives of the organized profession and those of the Blue Cross Plan and the Oregon hospitals to effect an understanding whereby the latter would limit their services to hospitalization and the former to medical services (Gov. Exs. 287, R. 2949; 370, R. 3235; 2055, R. 6351; R. 1512, 1679). During this period, the State Society designated several of the trustees of the Blue Cross Plan (Gov. Ex. 382, R. 3290).

Similarly, the supplying of chiropractic, osteopathic and dental services under prepaid medical care plans has been limited (Gov. Exs. 436, R. 3407; 494, R. 3536), although OPS now furnishes some of those services (Gov. Ex. 126, R. 2335).[89] It was the limited availability of osteopaths and chiropractors that led one employee group to shift

[89] Industrial Hospital Association eliminated chiropractic services from its contracts in 1942 due to the objection of the Clatsop County Medical Society (Gov. Ex. 2696, R. 6971). In 1947, in connection with individual coverage by OPS, the House of Delegates voted that no dental services be furnished (Gov. Ex. 1563, R. 5207).

from OPS to hospital association coverage (R. 796).

Although early prepaid medical care plans had provided liberally for the supplying of drugs and medicines to participants, the State Society by 1939 had adopted a policy opposing such provisions (Gov. Ex. 337, R. 3128–9).[90] Such policy was specifically reaffirmed in 1940 (Gov. Ex. 350, R. 3192). Except for very limited purposes, drugs were not supplied thereafter under medical society sponsored plans (Gov. Ex. 1118, R. 4643; *cf.* Gov. Ex. 2058, R. 6354).

SPECIFICATION OF ERRORS TO BE URGED

The district court erred:

1. In holding that none of the Government's charges had been proved.

2. In finding that appellees have not conspired and combined to restrain, or attempted to monopolize, the prepaid medical-care business in Oregon, and that such business has not been restrained or monopolized.

3. In finding that any restraints of trade imposed by appellees were not unreasonable.

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[90] In 1939, the Multnomah Medical Service Bureau, at the instance of the State Society, determined "that the Bureau and a committee of the Multnomah County Medical Society immediately contact the drugstore proprietors of Multnomah county with the objective of eliminating the supplying of drugs and medicines from the contracts of the Bureau" (Gov. Exs. 752, p. 4; 2022; 2023; not printed).

4. In finding that, if there was a conspiracy prior to 1941, it was terminated in 1941 or in the period 1941–1945.

5. In finding that the sale of medical services by doctor-sponsored organizations is not trade or commerce within the Sherman Act and in failing to find that the prepaid medical business in Oregon, no matter by whom conducted, is such trade or commerce.

6. In failing to find that the appellees' illegal activities involved and affected interstate commerce.

7. In failing to find and conclude that appellees had violated Sections 1 and 2 of the Sherman Act.[91]

SUMMARY OF ARGUMENT

I

The findings of the district court that appellees did not conspire to restrain and did not attempt to monopolize the prepaid medical care business in Oregon are clearly erroneous. Those findings were adopted as submitted by the appel-

[91] The foregoing specification of errors to be urged is a summary of the assignments of error upon which the Government relies. The Government specifically assigns as error assignments of error numbered 1–11, 14–17, 20–22, 25, 26, and 29.

The specific findings of the district court which the Government contends are clearly erroneous and should be set aside are listed in note 92, p. 101, *infra*.

lees, and the district court's opinion and notes contain no analysis of the evidence. The opinion and notes reflect, rather, the strongly held but erroneous view that the issue before the court was "socialized medicine" and, perhaps, "socialized law."

The Government's uncontradicted, and largely documentary, evidence clearly establishes the conspiracy and attempt charged, and the district court's contrary findings cannot be sustained by the record.

A. The existence of the conspiracy is shown by the joint action of, and close cooperation among, the State Society, the county medical societies, and the individual appellees in seeking to drive the hospital associations out of business and to vest control over all prepaid medical care plans securely in the organized medical profession. Cf. *American Medical Association* v. *United States*, 317 U. S. 519.

Under State Society urging, there was undertaken an extensive program of disciplinary proceedings against doctors affiliated with the hospital associations, combined with a widespread boycott of such associations by Oregon doctors. A number of doctors were expelled from the Multnomah County society, others resigned after being subjected to disciplinary proceedings, and many more gave up hospital association work after being called before the censors. These discipli-

nary proceedings received wide publicity, and doctors throughout Oregon were made aware that continued participation by them in hospital association work would be at their peril.

The medical society sponsored boycott was a correlative of the disciplinary proceedings. Under appellees' urging and coercion, a large number of doctors in the state refused to have anything to do with the hospital associations—refused to take their "tickets," to accept their checks, or to make reports to them. Many doctors specifically referred to medical society policy as the reason for their refusal to cooperate. In many counties, the boycott was instituted when a number of doctors wrote substantially similar letters announcing the same cut-off date for termination of their services.

As a result of this medical society sponsored boycott, a substantial number of accounts were lost by the hospital associations to medical society sponsored plans. One hospital association went out of business as a result of inability to obtain doctors to service its accounts; another went into the medical indemnity insurance business after its doctors had quit because of medical society pressure. Patients were harassed by the doctors' refusal to cooperate with the associations, and employers and the associations were burdened with extra clerical and administrative duties.

In addition to boycotting the hospital associations, appellees also conspired and attempted to

limit hospital staff privileges to medical society members.

Appellees' campaign against contract practice also was directed against fraternal and industrial work. The medical care program of the Eagles was restricted by appellees' attacks on the contracts under which physicians supplied medical care to members of that organization. Appellees similarly condemned railroad and industrial contract practice, urging doctors to see patients covered by such plans only as private patients.

In addition to their restraints of hospital associations and fraternal and industrial contract practice, appellees also restricted the operations of medical society sponsored plans. The admitted lack of competition between Oregon Physicians Service, the State Society plan, and the local society plans, has been the result of concerted action between the State and the local societies. Such an allocation of markets is illegal *per se* under the Sherman Act. Appellees also have restricted the medical care made available under medical society plans, by limiting the income level of subscribers, denying family coverage, and restricting the supplying of chiropractic and osteopathic services and drugs and medicines.

B. Appellees have combined, conspired and attempted to monopolize the Oregon prepaid medical care business. They had both the intent to elimi-

nate the hospital associations, and the power so to exclude them. Such monopoly power was acquired and maintained by practices which themselves constituted unreasonable restraints of trade.

C. Contrary to the findings of the district court, the conspiracy has not been abandoned. The "definite proof" required to show abandonment of a conspiracy, *Local 167* v. *United States*, 291 U. S. 293, 298, not only is lacking here, but the uncontradicted evidence shows that the conspiracy has continued. At no time did appellees repudiate the boycott or urge the profession to terminate it. On the contrary, the boycott has remained in force, and as recently as 1947 and 1948, doctors refusing to deal with hospital associations gave medical society policy as their reason therefor. Attacks on contract practice continued during 1945 and 1946. A number of accounts were lost by the hospital associations to OPS in 1946 and 1947 because of the doctors' refusal to cooperate.

II

Appellees' contention that any restraints they may have imposed were for the purpose of enforcing compliance with what they conceived to be the professional ethical standards embodied in the Principles of Medical Ethics of the American Medical Association would not, even if accepted, justify their conduct. Benevolent motives, or at-

tempts to enforce a "code of ethics," do not justify conduct otherwise violative of the Sherman Act. *Sugar Institute* v. *United States,* 297 U. S. 553; *United States* v. *United States Gypsum Co.,* 340 U. S. 76; *United States* v. *National Association of Real Estate Boards,* 339 U. S. 485. The hospital associations were legally authorized to operate, and appellees had no right to arrogate to themselves authority to condemn, the hospital associations, and make a concerted effort to drive them out of business. Moreover, it is clear that appellees' major concern with the competing associations was economic rather than ethical or benevolent—the competition such associations offered to physicians not engaged in contract practice.

III

A. Both the medical society sponsored plans and the hospital associations are engaged in trade and commerce under the Sherman Act. *American Medical Association* v. *United States,* 317 U. S. 519. They deal with the financial aspects of a medical care program, and provide "medical care and hospitalization on a risk-sharing basis (*ibid.*). The marketing of services as well as the sale of goods is within the trade or commerce whose restraint or monopolization the Sherman Act prohibits. *United States* v. *National Association of Real Estate Boards,* 339 U. S. 485; see *Apex Hosiery Co.* v. *Leader,* 310 U. S. 469, 493. The fact that appellees are members of a learned

profession does not exempt them from the Sherman Act, since that statute applies to "every person" who conspires to restrain or monopolizes trade or commerce. *American Medical Association* v. *United States, supra.*

B. In light of the above, it is unnecessary for the Court to decide whether any restrictions on the practice of medicine may involve a "restraint of trade" under the Sherman Act. In any event, however, the economic aspects of medicine do come within the statute. Congress used the phrase "restraint of trade" in the Sherman Act as words of art importing the common law concept which they connoted. At common law, contracts restricting the right of a doctor to practice his profession were treated as contracts in "restraint of trade," and their validity was determined by the usual standard of reasonableness applicable to such agreements. See, *e. g., Pratt* v. *British Medical Ass'n* [1919] 1 K. B. 244.

IV

The conspiracy involved and affected interstate commerce. The Oregon prepaid medical care plans have sold medical care policies outside the state. They actively solicit such out-of-state business, and send sales representatives into other states to sell and service policies there. Substantial interstate correspondence is conducted by the Oregon prepaid medical care plans. Thus the

Oregon plans themselves are "doing business" in other states, and are directly engaged in interstate commerce. *Polish National Alliance* v. *National Labor Relations Board,* 322 U. S. 643.

Customers of the Oregon prepaid medical care plans include firms engaged in interstate commerce. The rendering of service to those engaged in such commerce brings such service within the Federal commerce power. In addition, employees are covered by the Oregon prepaid medical care plans while outside of Oregon. A subscriber needing medical attention while outside the state is treated by a local doctor or hospital, and the medical care association then pays such out-of-state practitioner or institution. The number of such out-of-state treatments is considerable, and it results in the prepaid medical care plans engaging in a substantial volume of interstate commerce. There is present in this case the same "continuous and indivisible stream of intercourse among the states" that characterizes the fire insurance business, held to be interstate commerce in *United States* v. *South-Eastern Underwriters Association,* 322 U. S. 533.

ARGUMENT

I

Appellees conspired to restrain and monopolize the prepaid medical care business in Oregon

A. INTRODUCTION

The district judge made 51 detailed findings in this case. The Government is seeking to overturn, in whole or in part, 20 of them.[92] Prior to discussing them in detail, however, we think it important to consider the scope of judicial review of such findings by the Court in this case.

Rule 52 (a) of the Federal Rules of Civil Procedure prescribes that in actions tried without a jury findings of fact shall not be set aside by appellate courts "unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the

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[92] The Government specifically challenges the correctness of findings 20, 21, 22, 23, 24, 25, 26, 30, 31, 32, 33, 37, 38, 39, 40, 41, 42, 43, 46 and 47. In addition, there are certain other findings that the Government deems ambiguous, and which it does not challenge unless they are construed in a particular way. We discuss those findings at the pertinent points in the Statement and Argument. See note 77, p. 69; note 4, p. 121; note 13, p. 131.

There are other findings that it is not deemed necessary specifically to challenge but that are erroneous in certain particulars. Such errors are pointed out in note 69, p. 64; note 82a, p. 82; note 22, p. 148.

Not all of the challenged findings are purely factual. Thus, for example, we believe that findings 30, 41, 43 and 46 constitute legal conclusions in whole or in part.

witnesses." Recent decisions in antitrust cases have made it clear that where a reasoned opinion has preceded or accompanied such findings, and the findings are based upon the district court's resolution of conflicting testimony, especially as to motive and intent, the Court is reluctant to reexamine the evidence upon which they are based. *United States* v. *Yellow Cab Co.*, 338 U. S. 338; *Timken Roller Bearing Company* v. *United States*, 341 U. S. 593. However, as the earlier decision in *United States* v. *United States Gypsum Co.*, 333 U. S. 364, 395, declared, a factual finding is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." In the *Gypsum* case, the Court reversed several of the district court's crucial findings. It did this despite testimony by the authors of certain documentary exhibits that had been relied on "very largely" by the Government, that they had not acted in concert in securing patent license, or had not agreed to do the things that were, in fact, done. In so doing, the Court pointed out that "Where such testimony is in conflict with contemporaneous documents we can give it little weight, particularly when the crucial issues involve mixed questions of fact and law." *Id.* at 396. Hence, the Court concluded that particular findings were clearly erroneous "Despite the opportunity of the trial

court to appraise the credibility of the witnesses." [93]

In the instant case, the Government's documentary evidence was entirely uncontradicted and the testimony of the Government's witnesses was, except in some minor aspects, similarly uncontroverted. The Statement is based upon this unimpeached evidence. Appellees' case consisted of emphatic, but general, denials that they had acted (or at the time of trial continued to act) in concert or had endeavored to restrict the prepaid medical care business, affirmations that the disciplinary proceedings and boycott were not the result of concerted action, and attacks on the practices of the commercial hospital associations which had led to the appellees' disapproval on "ethical grounds."

Appellees' testimonial protestations of innocence are entitled to "little weight" because they are "in conflict with contemporaneous documents." *United States* v. *United States Gypsum Co.*, 333 U. S. 364, 396. And in determining how much reliance is to be put upon the district court's findings, the reasoning and care taken in

[93] Recent decisions of the various courts of appeals similarly have overturned trial courts' findings of fact as "clearly erroneous" under Rule 52 (a). *Orvis* v. *Higgins*, 180 F. 2d 537 (C. A. 2), certiorari denied, 340 U. S. 810; *Chatz* v. *Armour Plant Employees' Credit Union*, 145 F. 2d 236 (C. A. 7), certiorari denied, 329 U. S. 728; *Harris Stanley Coal & Land Co.* v. *Chesapeake & O. Ry. Co.*, 154 F. 2d 450, 452–3 (C. A. 6), certiorari denied, 329 U. S. 761; *Fleming* v. *Palmer*, 123 F. 2d 749, 751 (C. A. 1), certiorari denied, 316 U. S. 662; *Aetna Life Ins. Co.* v. *Kepler*, 116 F. 2d 1, 5 (C. A. 8).

preparation of the trial court's opinion must weigh heavily in the balance. In the *Yellow Cab* case, *supra,* the district court's opinion was described as one "prepared with obvious care, which analyzes the evidence and shows the reasons for the findings" (338 U. S. at 340–1). Here the opinion and notes of the district judge reveal, we believe, not only a failure to analyze the evidence with care, but a complete misconception of the issues in the case. Indeed, the judge's opinion and notes suggest that his findings—"mechanically adopted" with but one slight change from those proposed by appellees (R. 7508), cf. *United States* v. *Forness,* 125 F. 2d 928, 942 (C. A. 2), certiorari denied, 316 U. S. 694—reflect a strongly, but erroneously, held notion of the issues involved and a conviction as to how such issues should be resolved, not resting on any judicial evaluation of the evidence bearing on the issues made by the pleadings. His opinion, covering only 2½ pages in the printed reports, does not analyze or discuss any of the evidence, and cites no cases.

The judge's findings must be read in conjunction with the series of "notes" appended to his opinion (R. 2009). These notes, made by him during the trial, reflect his belief that one of the issues in this case was whether "organized medicine must remain a sitting duck while socialism overwhelms it?" Note 13, R. 2011–2012). Apart from tangential comments on medical care at sea in the last war (Note 22, R. 2014) and the threat of sociali-

zation of the law implicit in what was said to be the trend and drift toward socialized medicine (Note 17, R. 2013), the trial judge's notes are in large measure comments indicating that in his view the supposed threat of socialized medicine was a significant factor in this case.

Thus, Note 12 (R. 2011) describes this case as "an attack on the professions." Note 13 (R. 2011) states that "Leaders among the doctors maintain the view that doctor-owned prepaid medical plans are the profession's answer to socialism." Note 14 (R. 2012) announces that "Socialized Medicine may overtake them but the doctors claim the right to save the profession from socialism. That is what this case is about, according to the doctors' viewpoint." "What was the purpose of the doctors in organizing the Oregon Physicians' Service?" Note 15 (R. 2012) inquires. "Was it to obtain a monopoly in the prepaid medical field, or was it to save themselves and their profession from threatened socialization? I hold it was the latter and that nothing in the anti-trust laws deprives them of the right to fight to defend their independent professional status. That is entirely different from whether socialization can be lawfully forced on them."[94]

[94] The broad approach of the judge, ignoring the issues and the evidence, is further reflected in Note 27 (R. 2016): "The present case represents an effort to apply the decision obtained against the American Medical Association (317 U. S. 519) to Oregon. The facts are different. The times are different."

Obviously, the question of socialized medicine has no place in this case. The sole issue is whether appellees have conspired and combined to restrain and monopolize the prepaid medical care business as the Government has charged. It is the Government's contention that the proof overwhelmingly establishes that they did so conspire and combine, and that there is no possible support in the record for the district court's contrary conclusions. Since it thus appears "that the trial court has failed to make a sound survey of or to accord the proper effect to all of the cogent facts * * *," *Nee* v. *Linwood Securities Co.*, 174 F. 2d 434, 437 (C. A. 8), this case falls within the category of situations where the Court has a "duty" to correct "clear error, even in findings of fact." *United States* v. *Yellow Cab Co.*, 338 U. S. 338, 342.

B. APPELLEES CONSPIRED TO RESTRAIN AND HAVE RESTRAINED AND ATTEMPTED TO MONOPOLIZE THE PREPAID MEDICAL CARE BUSINESS IN OREGON

Crucial to the district court's decision in this case are Findings 20 and 21. In Finding 20 (R. 2021), the District Judge found that "none of the defendants * * * have attempted to, or have been engaged in any combination or conspiracy to, restrain or monopolize the business of selling or furnishing prepaid medical care in the State of Oregon or elsewhere; or to restrain or monopolize interstate trade or commerce in said business;

nor do any of the defendants threaten or intend to do so." Finding 21 (R. 2021) denies the existence of any "conspiracy, agreement, combination or concert of action" among the appellees to do seven specific things that they had been charged with in the complaint, including "to *monopolize* or attempt to monopolize prepaid medical care business in the State of Oregon or between the State of Oregon and other states," "to limit the scope of medical care to be provided by prepaid medical care plans in the State of Oregon," "to prevent, hinder or obstruct prepaid medical care organizations other than those sponsored by defendants, or any of them, from continuing to engage in or from engaging in the business of selling or furnishing prepaid medical care in Oregon or elsewhere," and "to prevent doctors from cooperating in prepaid medical care plans not sponsored or approved by defendants." The Finding concludes that "None of the defendants has conspired or combined or agreed or proceeded by concert of action or otherwise to restrain or monopolize trade or commerce in the manner or by the means charged in plaintiff's complaint, or otherwise." Taken together, these two Findings, if correct, negate any conspiracy by appellees to restrain or monopolize the prepaid medical care business in Oregon as charged in the complaint.

We submit that the uncontradicted evidence in this case compels the conclusion that appellees did

in fact so combine and conspire. Indeed, seldom does an anti-trust case furnish such a clear and open reord of a conspiracy to suppress competition. The record here discloses that the state and local medical societies had "a unity of purpose" and "a common design or understanding" (*American Tobacco Co.* v. *United States,* 328 U. S. 781, 809–810) to eliminate prepaid medical care plans they disapproved, and that they worked closely together toward achieving that aim. While each of the appellee county societies is "to a limited extent affiliated" with the state society (Fdg. 3, R. 2018), it is nonetheless a separate entity capable of engaging in a conspiracy with both its fellow societies and the state organization. *United States* v. *Yellow Cab Co.,* 332 U. S. 218, 227; *Schine Chain Theatres* v. *United States,* 334 U. S. 110, 116.

1. THE ORIGIN AND PURPOSES OF THE CONSPIRACY

This Court has already had occasion to review the methods employed by the American Medical Association and the Medical Society of the District of Columbia in attempting to stifle Group Health Association, a cooperative prepaid medical care plan in the District of Columbia. Cf. *American Medical Association* v. *United States,* 317 U. S. 519. The instant case developed out of the efforts of organized medicine in Oregon to eliminate another type of competitive challenge—this time in the Pacific Northwest—and involves an application by the organized profession of many

of the same techniques that characterized its attack on Group Health. The record here reflects an unrelenting opposition to any form of prepaid medical care, not under the control of the organized profession, that threatened the doctors' economic position. The conspiracy "had as its purpose a restraint of the free availability of medical or hospital services in the market * * *." *American Medical Association* v. *United States*, 317 U. S. at 529.

That the conspiracy here involved was economically and not ethically motivated is strongly suggested by its origin. Although the hospital associations had been selling prepaid medical care policies in Oregon since early in the century, it was not until the depression that the appellees became actively concerned with the inroads they were making. And see *infra*, pp. 156–164. The Multnomah County Medical Society prepaid medical care plan had been organized in 1932 with the hope that it would "attract much of the work which was going to the then organized hospital association" (*supra*, p. 25). These expectations were not fulfilled, however, for the operations of the plan resulted in "a decreased income" for participating doctors from patients "able to pay customary fees," led to loss of "some of these patients" by nonplan doctors, and "had no appreciable effect" upon the hospital associations, since its subscribers were "largely" drawn from

persons who had "never before been brought under a scheme of contract medicine" (*supra*, p. 28). The plan had failed in its objectives, and the Multnomah County Society disapproved it as operating in violation of the Principles of Medical Ethics [95] (*supra*, pp. 26–7).

More vigorous methods were deemed necessary to meet the challenge of the hospital associations. The State Society took over the campaign. Having employed counsel who prepared an outline of procedure for the local societies in conducting disciplinary proceedings, the State Society, in 1936, issued its call to action by distributing to the membership a statement of policy relating to the "enforcement of the Principles of Medical Ethics" (*supra*, pp. 29–30). The statement indicated that the State Society was contemplating action relating to hospital association practice if the local groups failed to rectify the situation. It noted that the Council of the State Society was "especially concerned" with the "widespread violations" of the principles by the "commercial associations," it assumed a "duty * * * to assist the component societies to keep their houses in order," and it urged that members of such societies "engaged in unethical contract practice" be "requested to cease such activities and to conduct

[95] Subsequently the plan was revived on terms thought to be less detrimental to the economic interest of the private practitioner (*supra*, p. 28, n. 32).

themselves in accordance with the Principles of Medical Ethics" (*supra,* pp. 31–2, italics supplied).

This call to action was heeded by the county societies. Numerous local meetings were held at which representatives of the State Society discussed the applicability of the Principles of Medical Ethics to contract practice (*supra,* p. 32). The tie between the local and state levels was strengthened further, later in 1936, when members of the component societies undertook to submit their prepaid medical care contracts to the executive committee of the Council for approval (*supra,* p. 33) and the State Society condemned the hospital associations for "operating in contravention of the decisions of the Judicial Council of the AMA" (*supra,* p. 34). Such close cooperation continued. The State Society frequently reminded the local groups of what it expected of them, and the local groups in turn sought advice from the State Society in dealing with the problem (*supra,* pp. 43–44).

Very early in this period, the State Society made it clear that its aim was elimination of the hospital associations and complete control of all prepaid medical care plans by the organized profession. In 1936, the Society pointed out that the Multnomah doctors' plan had been organized in the hope that "ultimately the commercial hospital associations * * * might be *driven from the field,*" and spoke of "making *a clean sweep*

of all hospital associations" (*supra,* pp. 26, 36). By 1938, the aim was "that some plan [of prepaid medical care for the low income groups] should be developed by the society *to replace the existing schemes of lay hospital associations* and groups of physicians." (*Supra,* p. 36; italics supplied.) A 1940 resolution of the State Society Council was that the Council "do not approve the plan of any hospital association that is not owned or controlled" by physicians who are members of their local and state society (*supra,* p. 37). Ownership and control of prepaid medical care plans by the profession was described in 1941 as one of the "established policies" of the State Society (*supra,* p. 37.) In 1946, the State Society policy was "to have all contracts for medical service made in and through the physicians' own prepaid organizations, and not with any private doctor or group of doctors (*supra,* p. 38). Clearly in appellees' eyes, prepaid medical care was to be the exclusive province of the organized profession.

2. THE METHODS OF THE CONSPIRACY

a. Restraints on Hospital Associations

(1) *Disciplinary Proceedings.*—Coupled with the State Society's 1936 policy pronouncement was a call for more vigorous action against doctors unwilling to mend their ways. In 1936 or early 1937, the State Society suggested to the com-

ponent societies that "in some instances" "it becomes the duty of the State Society to see that disciplinary measures are taken" (*supra*, p. 45). The State Society announced that it was ready to assist and advise the local groups "on any aspect of disciplinary action," and distributed an outline of procedure for the proper conduct of disciplinary proceedings in cases of "unethical contract practice" (*supra*, p. 43). Although the district judge found that "no other defendant [than Multnomah County Medical Society] has ever * * * threatened or incited the expulsion from medical societies of any doctors because of any cooperation in prepaid medical care plans * * *" (Fdg. 23, R. 2022), this is contradicted by documentary evidence that the State and at least two of the local societies did just that. In December 1939, the Council of the State Society directed that "unethical practices" in certain localities should be "scrutinized by the local societies" and "disciplinary action" taken against any members whose practices were found to be "unethical." It warned that failure of local societies to "invoke proper disciplinary proceedings" might "jeopardize" their affiliation with the State Society, and set January 1, 1940 as the date for institution of such proceedings (*supra*, pp. 43–4). Upon receipt of the foregoing pronouncement from the State Society, the Jackson and Lane County Societies promptly passed

resolution announcing that members working for lay-owned hospital associations would have their membership terminated (*supra*, pp. 44–5). "Disciplinary action," viewed in the light of the proceedings that had concededly taken place in Multnomah County, could mean but one thing—expulsion. The fact that there were no disciplinary proceedings relating to hospital association practice after 1941, as stated in Finding 23, is immaterial since, as pointed out pages 114–117, *infra*, by that time the pattern had become established so clearly that institution of formal proceedings no longer was required to keep the doctors in line.[98]

The significance of the foregoing medical society pronouncements and resolutions must be considered in the light of what had already happened. Beginning in 1936, shortly after the Multnomah County Society had disapproved the Multnomah doctors' plan, an extensive program of disciplinary proceedings in Multnomah County against doctors affiliated with the hospital associations was instituted. Doctors so connected were summoned before the censors, asked to explain their contracts, and then warned to terminate such contracts on pain of expulsion. A number of doctors were expelled. Others re-

[98] Moreover, preliminary disciplinary proceedings were instituted as recently as 1948 in connection with fraternal practice (*supra*, p. 50).

signed after charges had been preferred against them. Still others terminated their hospital association affiliation when faced with the threat of punishment. The number of such disciplinary proceedings was extensive; more than forty doctors were expelled, resigned or gave up their hospital association work pursuant to express and individualized directives of the medical societies (*supra,* pp. 46–7).

The thoroughness and effectiveness of this weapon in the profession's campaign against the hospital associations does not sufficiently appear from a bare statement as to the number of doctors actually subjected to disciplinary action. Similarly, the fact that formal disciplinary proceedings were conducted only by the Multnomah County Society, and that they ended in 1940, did not restrict their reach. The disciplinary proceedings received wide publicity, and doctors throughout the state were made fully aware of the treatment received by nonconforming members of the profession. The State Society publicized its approval of disciplinary proceedings as a method of combating hospital association practice at a time when a number of such proceedings already had been held (*supra,* pp. 43–4). The knowledge of such proceedings and the State Society's attitude toward them was a sufficient warning to the smaller local societies to "keep their houses in order" *supra,* p. 32). Subtle influences may be just as effective as the threat

or use of formal sanctions to hold people in line." *United States* v. *National Association of Real Estate Boards,* 339 U. S. 485, 489.[96a] Moreover, many members of the profession presumably would conform to medical society policy without subjection to any overt pressure.

The peculiar effectiveness of disciplinary proceedings as a coercive technique stemmed from the unique relationship between the medical profession and the medical society. The latter's position is quite different from that of the typical professional or trade association. The medical society plays a far more significant role in the professional life of the average doctor than a comparable organization in another field. In addition to the tangible detriments that loss of membership entails (see *supra,* pp. 23–24), there are the even more compelling intangible factors of loss of prestige and feeling of isolation that a doctor experiences when cut off from his colleagues in their professional organization. The clearest evidence of the attitude of the profession toward medical society membership is the large number of Oregon doctors who, though unpersuaded by their brethren on the "merits", were willing to give up their profitable hospital association work when threatened with disciplinary action. Although Finding 34 (R. 2025) correctly states that membership in any of appellee medical

[96a] In the *Real Estate Boards* case no disciplinary proceedings had been invoked to enforce the illegal agreement embodied in the code of ethics.

societies has no effect under Oregon law on the privilege of practicing medicine, that fact does not negative the great importance to a doctor of his medical society membership. The significant point is that nonmembership handicaps a doctor in the practice of his profession, and that the mere threat of such handicap has been sufficient to induce him to abandon practices frowned on by the organized profession.

The fact that the disciplinary proceedings may have been carried out fully in accordance with the applicable charter and by-law provisions of the society is immaterial.[97] What is condemned is not the conduct of disciplinary proceedings, *per se*, but their use as a step in appellees' campaign against the hospital associations.[98] Conduct otherwise legal and proper may become tainted when it is a means of accomplishing an illegal objective.

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[97] In fact, the employment of an attorney by the State Society to aid the local societies in dealing with "problems arising from unethical contract practice" (*supra*, pp. 34–5) suggests an endeavor to conform strictly to the technical niceties of procedural requirements.

[98] The mere conduct of disciplinary proceedings under the circumstances of this case, with its concomitant effect on admissions, itself may have involved a violation of the Sherman Act. Refusal to admit competitors or persons dealing with competitors to a trade group having monopoly power solely because of their competitive position is an unreasonable restraint of trade. *Associated Press* v. *United States*, 326 U. S. 1; *American Federation of Tobacco Growers* v. *Neal*, 183 F. 2d 869 (C. A. 4); cf. *Greenleaf* v. *Brunswick-Balke-Collender Co.*, 79 F. Supp. 362 (E. D. Pa.). The same result should follow where the restraint takes the form of expulsion instead of refusal to admit.

American Tobacco Company v. *United States*, 328 U. S. 781, 809. The basic misuse of disciplinary proceedings in this case is emphasized by the fact that during the entire period of this conspiracy, not a single disciplinary action was brought for any misconduct other than hospital association affiliation.

(2) *Boycott.*—The conduct and encouragement of disciplinary proceedings was only the first step in the carrying out of the conspiracy. Its correlative was a medical-society-sponsored boycott of the hospital associations by the profession.

As previously noted, appellees' aim in their campaign against the hospital associations was to put them out of business and thus vest control over all prepaid medical care plans in the organized profession. Obviously, the most effective method of accomplishing this result would be to get the doctors to cease dealing with the associations in any way.

At the same period in 1936 when the State Society urged the taking of disciplinary action against doctors engaged in contract practice with the associations, it also indicated approval of the conduct of one local society in "acting as a unit" in informing the hospital associations that it would not attend the patients of such groups (*supra*, p. 53). Four years later, with the boycott well under way, the State Society listed the very things that the boycotting doctors were refusing to do as acts which, if performed, could be

regarded by the local societies' disciplinary bodies as "some evidence of association" with "unapproved organizations or organizations engaged in unethical practice." They included accepting "tickets" of such organizations, billing them directly, accepting their checks directly from them or endorsed by the patients, and giving them reports covering the patient's condition (*supra*, pp. 54–5). In other words, the State Society served notice on the profession that it approved the use of boycott as a weapon against the hospital associations, and that failure to join in the boycottt might itself involve association with "unethical organizations" that could constitute a cause for disciplinary action.

That the boycott involved concerted action pursuant to the conspiracy is, we submit, clearly established by the evidence. Concerted action among doctors is shown not only by the activities and pronouncements of the state and local societies, but also by the way in which the boycott was initiated. In many of the counties, its onset was heralded in letters written to the hospital associations and to industrial concerns by a substantial number of doctors, each giving the identical date for termination of hospital association work.[99]

[99] For example, fifteen Lane County doctors notified National and Industrial in November 1937 that they would not treat patients under their contracts after January 1, 1938 (*supra*, p. 63). Appellees' counsel conceded in his opening statement that there had been concerted action among doctors in Lane (R. 337) and Jackson (R. 338) Counties in boycotting the associations, and made a similar concession later in the trial (R. 942).

We submit that there is no clearer evidence of concerted action than the joint cessation of services under such conditions. Moreover, in at least one society, Lane County, such letters were written following adoption of a formal resolution by the group that its members would discontinue work for "unethical associations" after that date (*supra*, pp. 62–3).

Under medical society urging, the boycott has remained in force.[1] As recently as 1946, Northwest Medicine explained to doctors that when seeing contract cases as private patients they were under "no obligation whatsoever to make any kind of report to a third party upon the condition of his patient" (*supra*, pp. 56–7). Moreover, failure of the state and county societies to disavow their previously announced policy of boycott carried with it the clear implication to the medical profession that it was to be continued. That the profession understood this to be the accepted policy is seen in the number of doctors in recent years who have given such medical society policy as their reason for returning hospital association checks.

For example, in 1947, a Clatsop County doctor refused to accept a National check because "Due to a ruling of the Clatsop County Medical Association no doctor can accept checks from the com-

[1] The continuation of the conspiracy is more fully described in our discussion of abandonment, pp. 146–150, *infra*.

pany," and a Jackson County doctor explained that "In compliance with the policy established by the Jackson County Medical Society," he was "not in a position" to accept payments directly from National (*supra*, pp. 65–6).[2] These spontaneous writings are far more reliable evidence of the views of the Oregon medical profession than solemn avowals by appellees' doctor witnesses that their refusal to deal was a matter of individual uninfluenced decision.[3] They refute completely the conclusion in Finding 47 (R. 2028) that even if a boycott existed in the past, there has been none "in recent times" and that appellees have no intention to boycott the hospital associations in the future.[4]

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[2] For additional examples of such letters, see pp. 66–7, *supra*.

[3] Appellees' calling only two of the authors of these letters as their witnesses, and their reliance on the general denials of *other* doctors that the latter had acted in concert pursuant to medical society policy, suggests that the testimony of the other letter writing physicians, had they been called, would have substantiated their written admissions. "The production of weak evidence when strong is available can lead only to the conclusion that the strong would have been adverse." *Interstate Circuit* v. *United States*, 306 U. S. 208, 226.

[4] Finding 26 is that "none of the defendants at any time has refused to treat patients or caused others to refuse to treat, or combined or conspired to refuse to treat any patients who were members of any prepaid medical care plan, or discriminated against any such patients by reason of such membership" (R. 2022). If "refused to treat" means refused to treat as hospital association patients, the Government views

The question of taking "tickets" (treatment requisition slips issued by a medical care organization) must be considered in the light of this medical society policy against cooperating with the hospital associations. It was a method adopted by appellees in the belief that it would injure the associations, and was but one aspect of the over-all policy of non-cooperation. Thus viewed, refusal of doctors to take tickets, to accept hospital association checks, or to give itemized statements concerning the patient's condition, constituted deliberate, combined interfer-

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the finding as erroneous, since the evidence is clear that appellees consistently urged Oregon doctors to see hospital association patients only as private patients (*supra*, pp. 56–7), and that many Oregon physicians gave such medical society policy as their reason for refusing to deal with the hospital associations (*supra*, pp. 59–62). Moreover, all of the individual appellees have refused to take tickets of the hospital associations (R. 431, 573).

However, if Finding 26 merely refers to a refusal to treat patients at all because of their hospital association coverage, then the Government does not attack it. But cf. the Lane County Medical Society's resolution that hospital association patients should be rendered emergency treatment only. See *supra*, pp. 64–5.

In any event, it is clear that several of the individual appellees have discriminated against patients with hospital association coverage, since they have refused to take the tickets of those organizations (R. 1125, 1296, 1343, 1506, 1601–2) while at the same time accepting OPS treatment requisiitons (R. 1114, 1125, 1295, 1342, 1356, 1506).

ences with the operation of hospital associations.[5] The record shows that such interferences caused serious inconvenience and even hardship to the subscribers, burdens on employers, and loss of business to the associations. Participation in a prepaid medical care plan is intended to relieve the subscriber of the worries and details of the financial aspects of medicine in return for a fixed monthly payment (Cf. R. 668). When a doctor refuses to take the "ticket," it means that the patient, despite his coverage under the plan, has to pay the doctor himself. Sometimes he obtains the money from the association first, or he may pay the doctor initially and then seek reimbursement from the association. There were patients who, having paid medical care premiums in advance, did not have the additional cash to pay the doctor while awaiting reimbursement from the hospital association (*supra, pp.* 53–4). The latter problem became particularly acute when patients had to meet substantial hospital bills from hospitals refusing to take tickets.

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[5] The fact noted by the district court (Fdg. 46, R. 2028), that the hospital associations' contracts, which are with the subscribers and not with the doctors, do not in terms obligate the associations to pay the doctors directly is irrelevant to whether the doctors were justified in combining to refuse to take tickets. For the *practice* of the associations was to pay the doctors (R. 425, 477), and the associations' fee schedules indicated to doctors that the associations would make payments directly to them (Gov. Exs. 71, R. 2176; 2718, R. 7011).

Patients frequently were required to make extra visits to the doctor to secure adequate information or to pay him. A patient without a bank account had the additional problem of cashing a hospital association check to obtain the funds for making payment. The patient was subjected to annoyance, embarrassment, and extra work. As one subscriber put it: "What is the meaning of all this? I pay $3.00 a month for this service and no doctor will take this form. I had to do all the red tape. If this continues I will have to drop out of the N. H. A. and pay my own Bills. * * *" (Gov. Ex. 11, R. 2122).

The uncontradicted evidence is that a substantial number of accounts was lost by the hospital associations to medical society sponsored plans as a result of employee and employer dissatisfaction with the doctors' refusal to deal with the hospital associations and the resulting annoyances and extra work (*supra*, pp. 67–8).[6] Clearly, the boycott had just the effect appellees desired—hurting the business of the hospital associations.[7]

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[6] The effectiveness of the boycott was facilitated by the availability of coverage under OPS. Moreover, the existence of a medical society sponsored plan to which the prepaid medical care business could be diverted protected the boycotting doctors from the loss of income that otherwise would have resulted from giving up hospital association work.

[7] This loss of business is the complete answer to certain testimony by the general manager of National Hospital Association, later clarified, that it would "make no difference" to the association whether a doctor took the ticket or merely gave the patient an itemized statement (R. 586;

Under these circumstances, a doctor cannot be deemed to have "cooperated with the Association," as the district court found, "if the patients receive from the doctors itemized statements of services rendered" (Fdg. 46, R. 2028).

Judge McColloch's conclusion in Finding 46 that refusal of doctors to take tickets or to accept payment from privately owned associations "is not boycott" is clearly erroneous. As we have shown, refusal to take tickets of, accept payment from, the associations were aspects of the overall policy of warfare against hospital associations. Boycott is the refusal to deal. Cf. *Fash-*

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cf. R. 1755). The most he could have meant was that, from the operating point of view, it was immaterial whether the association made payment directly to the doctor or reimbursed the patient. Obviously, a practice that resulted in loss of business must have made a great deal of difference to the association. The general manager's later testimony on rebuttal that his prior testimony had been in error, and that it made "a lot of difference" whether doctors took tickets (R. 1879), obviously is a correct statement of the association's interest in the matter.

Similarly, the statement by Dr. Moore, the president of Industrial, that it was "all right" with his organization "if a doctor cooperates with you by giving the patient an itemized bill that fully covers it so that you can tell whether the patient is covered, and the patient sends the bill to you and you pay the patient" (R. 388), was not made with reference to the problem of loss of business resulting from the boycott. Furthermore, Dr. Moore indicated that in "a portion" of the cases his organization was "embarass[ed]" when the bill was sent in by the patient (R. 389), and that the doctors' refusal to take tickets did cause the association "a great deal of excess work in our office" and "a great deal of work on the outside" (R. 383).

ion Originators Guild of America v. *Federal Trade Commission*, 114 F. 2d 80, 84 (C. A. 2), affirmed, 312 U. S. 457.[7] Here appellees sought to induce or compel Oregon doctors to refuse to deal with the hospital associations by refusing to take tickets, accept checks, or give statements. Such a boycott of competitors frequently has been condemned by this Court as a violation of the Sherman Act. *Eastern States Retail Lumber Dealers' Association* v. *United States*, 234 U. S. 600; *Fashion Originators' Guild of America* v. *Federal Trade Commission*, 312 U. S. 457; *United States* v. *Frankfort Distilleries, Inc.*, 324 U. S. 293; see *United States* v. *Columbia Steel Co.*, 334 U. S. 495, 522.[8]

In the *Eastern States* case, an association of retail lumber dealers circulated among its members the names of wholesale dealers who sold directly to the retail dealers' customers. The result of the practice, the Court found, was a boycott by the retailers of the offending wholesalers. In finding that this conduct constituted an unreasonable restraint of trade, the Court pointed out that it not only prevented the listed whole-

[8] In *Federal Trade Commission* v. *Wallace*, 75 F. 2d 733 (C. A. 8), the court affirmed, with minor modifications, a Commission order enjoining the activities of a coal dealers' association, as unfair methods of competition under Section 5 of the Federal Trade Commission Act, in inducing coal producers, by boycott and intimidation, not to deal with non-members.

salers from competing with the retailers, but also (234 U. S. at 612):

> directly tends to prevent other retailers who have no personal grievance against him and with whom he might trade from so doing * * * In other words, the trade of the wholesaler with strangers was directly affected, not because of any supposed wrong which he had done to them, but because of the grievance of a member of one of the associations who had reported a wrong to himself, which grievance when brought to the attention of others it was hoped would deter them from dealing with the offending party.

Similarly, in the instant case, the pressure applied by appellees induced doctors to cease dealing with the hospital associations, not because of any grievance they had, but because of appellees' complaints.

In the cases above cited, the boycott was a pressure device intended to force those boycotted to conform to the boycotters' demands. *A fortiori,* a boycott is unlawful where the purpose of the refusal to deal is to put its object out of business.

Under these circumstances, there is no warrant for Judge McColloch's finding that "as competitors [of the hospital associations], the defendants and other doctors of Oregon have conducted their organizations fairly and well within the legal limitations of competitive business practice"

(Fdg. 40, R. 2026). On the contrary, appellees' concerted campaign of boycott and other pressure devices constituted illegal and unfair trade practices aimed at the destruction of business competitors.

Judge McColloch's finding that there was no conspiracy to refuse to give itemized statements of service to patients (Fdgs. 27, 46, R. 2023, 2028) even if supported by the record (compare *supra*, p. 64), would not negative the existence of the boycott. The district court's finding that a doctor cooperated with the hospital association if he gave an itemized statement of services to the patient (Fdg. 46, R. 2028) may explain its conclusion that failure to take tickets or accept checks is not boycott, but it fails either to refute or reflect the clear evidence that appellees consistently urged a policy of non-cooperation in all aspects and insisted on a refusal to "take tickets" as a prime method of non-cooperation.

Appellees' principal contention respecting the boycott was that the doctors refrained from dealing with the hospital associations not because of any organized boycott, but because they disliked working for the associations.[9] A number of doctors testified to this effect,[10] and appellees introduced documentary evidence purportedly

[9] Cf. Appellees' Statement in Opposition to Statement as to Jurisdiction, paragraph III (8).

[10] A number of doctors, however, felt it necessary to conceal from the medical societies that they were dealing with the hospital associations (*supra*, p. 45, n. 44).

showing the reasons for such doctors' antagonism. However, the fact that some doctors may have given up hospital association practice on their own initiative for personal reasons does not negate the evidence that appellees' policy of non-cooperation caused other doctors to boycott the associations, not *sua sponte,* but because of such policy. The issue here is not the right of individual doctors to refrain from dealing with hospital associations, but appellees' concerted action to coerce or persuade them to follow such a course of action.

A boycott is not justifiable on the ground that not everyone concerned participates in it. *United States* v. *General Motors Corporation,* 121 F. 2d 376, 405 (C. A. 7), certiorari denied, 314 U. S. 618. Furthermore, the contention of spontaneous individual action is hardly consistent with the evidence of concerted conduct of a number of doctors in a particular county fixing the same cut-off date for terminating their services.[11]

Appellees' contention that the boycott simply reflected refusal of individual doctors to work for

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[11] In fact, the members of one local medical society (Jackson County) specifically recognized the existence of the boycott when they adopted a resolution in 1940, "that the boycott of the National and Industrial Hospital Associations by our member-physicians be discontinued" (*supra*, p. 65). However, this resolution was not carried out in practice, since the evidence is clear that the boycott in Jackson County has continued. See *supra*, pp. 65–6.

the hospital associations is also inadequate to explain the refusal of many doctors even to accept hospital association checks. First, on many of the occasions when doctors refused such checks, they referred to medical society policy as the reason for such refusal.[12] Second, acceptance of such checks, particularly where the amount of the fee already had been determined between the doctor and subscriber on a private patient basis, does not involve the doctors in any way with the operating procedures of the associations. Since the doctor under such circumstances has no direct contact with the association and is receiving the fee that he had agreed upon with the patient, it can make no real difference to him whether he receives the sum through a hospital association check or from a patient who has himself received and cashed such check to obtain the funds.

The conclusion is inescapable that the only possible reason for the refusal of doctors to accept hospital association checks was to harass the hospital associations and to render their operations and survival more difficult.

The uncontradicted evidence is that there has been concerted action by appellees to have Oregon

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[12] On one occasion, the Lane County Society requested information from the State Society on whether it was unethical for a doctor to treat a patient and receive the customary fee when he knew the patient was receiving the money to pay the fee from the unethical association (note 67, *supra*, p. 63).

doctors boycott the hospital associations in every way possible, including refusal to take tickets of, accept checks from, or send itemized statements to, such associations. This boycott has been widespread and virulent, has led to the loss of a substantial number of accounts by the associations, and has caused hardship and difficulty for doctors, commercial firms, the associations and members of the public. In short, it has restrained trade and commerce in the prepaid medical care business. In view of such demonstrated restraints, it is immaterial that the boycott may not have been completely successful, that many doctors continued to deal with the associations, and that more accounts were not lost by the hospital associations despite the doctors' tactics. *United States* v. *General Motors Corporation,* 121 F. 2d 376, 405 (C. A. 7), certiorari denied, 314 U. S. 618.

(3) *Attempts to limit hospital privileges.*—The district judge's finding that appellees did not conspire or attempt to limit hospital privileges to medical society members (Fdg. 31, R. 2024) should be contrasted with the specific instances cited in the Statement where both state and local societies sponsored such a policy (*supra,* pp. 70–72).[13]

[13] In Finding 48 the district court found that "none of the defendants in any manner restrained hospitals or hospital services or the opportunities of doctors or of patients to obtain hospital services" (R. 2028–9). The Government contends that both hospital services and the opportunities of patients to obtain such services were "restrained" by

For example, a report on hospitals adopted by the State Society in 1936 urged that "The importance of requiring membership in the local medical society as a prerequisite to membership on a hospital staff should be constantly stressed" (*supra,* p. 70). The effectiveness of such threatened restrictions as a further pressure device to induce doctors to terminate hospital association practice cannot be underestimated, cf. *American Medical Association* v. *United States,* 317 U. S. 519—particularly when coupled with the medical society policy of disciplinary proceedings.

b. Restraints on Other Medical Care Programs

The commercial hospital associations were not the only groups whose activities aroused appellees' antagonism. Their campaign also was directed against the medical care programs of certain fraternal organizations, and against so-called railroad and industrial contract practice. It is significant that appellees offered no evidence on this phase of the case, and that the district judge made no findings in relation thereto. The Government's evidence stands unanswered, without even testimonial denials by appellees' witnesses

appellees' boycott and their endeavors to limit hospital staff privileges to medical society members. If Finding 48 is read as opposed to this contention, the Government deems it erroneous. However, if the finding be given the narrow construction that hospital association doctors were not denied the right to hospital facilities, and that patients were not denied hospital treatment altogether because of hospital association affiliation, it is not then challenged.

that they intended to restrain such forms of prepaid medical care.

(1) *Fraternal organizations.*—In appellees' view, affiliation with a medical care plan of an organization such as the Eagles or Moose was as great a sin as hospital association practice. Although many doctors were willing to serve as organization physicians for these groups for the remuneration provided, the organized medical profession did not approve of such activities and took steps to terminate them.

In Lane County, two doctors were "persuaded" to relinquish their contracts with the Eagles, one upon the assurance of the local society that no other members "can take over these contracts and retain their membership in the Society" (*supra,* pp. 75–6). The Jackson County Medical Society adopted a resolution in 1938 that no member of the Society was to be affiliated with the medical plan of any fraternal organization after May 1 (*supra,* p. 76). The next year, the State Society condemned as "unethical" the contracts under which the Moose employed lodge physicians (*supra,* p. 76), and by this time members of the profession were well aware of what was in store for them if they continued relationships under such "unethical" arrangements. The difficulties of the Eagles in obtaining doctors had become so great by the time of the trial that the organization's constitution authorized local aeries to dispense with the service of an aerie physician

whenever it had become impossible to obtain one "by reasons of the rules of any medical society * * *" (*supra*, pp. 76–7). Obviously, the campaign against fraternal practice had been highly successful.

(2) *Industrial contract practice.*—Appellees made it clear in 1944 and 1945 that in their view industrial contract practice, too, was to be condemned. Railroad contract practice was described in 1944 as "bordering on the order of prostitution of a noble calling" and doctors who refused to abandon it were "no longer entitled to any further consideration on the part of regular men of medicine" (*supra*, p. 77). In 1945, the State Society warned doctors engaged in railroad and other industrial contract practice that if they failed to follow the private patient policy, "other remedies may be applied" (*supra*, p. 78). Obviously, the spectre of disciplinary proceedings still was lurking in the background. Doctors who participated in a prepaid medical care plan organized by employees of a telephone company were condemned in 1947 for "selling both themselves and their colleagues down the river of cut-rate medicine to ultimate disaster" (*supra*, p. 79). To members of the profession who had seen the treatment received previously by their colleagues engaged in hospital association practice, these vitriolic attacks and thinly veiled threats carried a clear warning that continuation of industrial contract practice would subject the

offender to similar treatment by the "regular men of medicine."

c. Restraints on Medical Society Sponsored Plans

In addition to restraining the "commercial" medical care plans, appellees also inhibited the activities of the medical society sponsored programs. Their complete control over these groups paved the way for elimination of any competition among them, and restriction of the coverage and services provided along lines deemed appropriate by the organized profession. Moreover, such lack of competition among the medical society sponsored plans enabled the profession to present a united front against its competitors.

(1) *Elimination of competition.*—Appellees admit (Gov. Ex. 1751, R. 5339), and the district judge found (Fdg. 30, R. 2023), that Oregon Physicians Service does not compete with any of the local doctor-sponsored plans.[14] However, he also found that such noncompetition was not the result of any conspiracy or combination (*ibid*).

We submit that the record shows that this policy has been achieved only through concerted action between the state and county societies. The State Society took the lead in enforcing the policy; it assured the profession upon the organization of OPS that its "operations will be con-

[14] OPS enters a new area only upon the invitation or consent of the local medical society, and has turned down requests for coverage in areas served by a local plan to avoid competition with the latter.

ducted only by approval of the local medical society in any involved area (*supra*, p. 84). Such noncompetition was a logical development from the earlier policy of noncompetition among local medical society sponsored plans (*supra*, pp. 83–4).[15] The local societies have cooperated in carrying out the policy.

"The Sherman Act seeks to protect the public against evils commonly incident to the unreasonable destruction of competition * * *." *Paramount Famous Lasky Corporation* v. *United States*, 282 U. S. 30, 43. A restraint of competition resulting from such concerted allocation of markets as here exists repeatedly has been condemned as an unreasonable restraint of trade in violation of Section 1 of the Sherman Act, and is, indeed, unlawful per se. *Addyston Pipe & Steel Co. v. U. S.*, 175 U. S. 211, 241; *United States* v. *Yellow Cab Co.*, 332 U. S. 218, 229; *Timken Roller Bearing Company* v. *United States*, 341 U. S. 593; *United States* v. *National Lead Co.*, 63 F. Supp. 513 (S. D. N. Y.), affirmed, 332 U. S. 319; see *Apex Hosiery Co. v. Leader*, 310 U. S. 469, 497; *United States* v. *Aluminum Co. of America*, 148 F. 2d 416, 427 (C. A. 2); cf. *Shawnee Compress Company* v. *Anderson*, 209 U. S.

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[15] The State Society had aided the county societies in eliminating competition from other local plans, as when it helped the Benton and Columbia societies in terminating certain contracts that the Multnomah County plan had written in their areas. See *supra*, p. 84, note 83.

423. Nor is such lack of competition justified because appellee county medical societies are "to a limited extent affiliated" with the State Society (Fdg. 3, R. 2018), which in turn has "sponsored and approved" OPS (Fdg. 2, R. 2017). Cf. *United States* v. *Yellow Cab Co.*, 332 U. S. 218, 229.

On this phase of the case, the district judge apparently misunderstood the Government's position. In Finding 30 (R. 2023), he concluded that "competition between two doctor-sponsored plans in a single county is impractical, since the same doctors must render services under whatever plans are in operation." He stated in Note 4 (R. 2009) that "Obviously, two doctor-sponsored plans, one statewide, the other local, could not operate in Klamath County, to take an instance," and charged the Government with having "fallen into absurdity" for what he conceived to be the Government's position that "OPS should use X county physicians to compete with X county physicians."

Of course, the Government never suggested that physicians be required to compete with themselves. The vice here is not lack of competition among doctors in the rendering of medical service, but concerted action by appellees to prevent competition among prepaid medical care plans. That such competition is feasible is shown by the fact that the medical society sponsored plans aggressively compete with the hospital as-

sociations, and that the hospital associations compete among themselves.[16] Yet all the plans must utilize the services of Oregon doctors. The competition is as to which organization shall write the medical care policy, and not as to which doctor shall render the treatment. In fact (apart from the appellees' efforts to prevent OPS-affiliated physicians from treating patients of other plans), the same physician might be consulted whether the coverage was under OPS or a hospital association, since in each instance the plan merely pays the particular doctor selected by the patient.

Absence of competition between OPS and the local doctor-sponsored plans obviously has resulted in restricting the prepaid medical care business, contrary to Finding 30. The benefits of competition that the Sherman Act is intended to secure (cf. *United States* v. *Trenton Potteries Co.*, 273 U. S. 392, 397) are diminished if a local medical society plan is assured that it will not be required to meet the competitive challenge of OPS. On the other hand, if those who operate a local plan know that OPS is offering or may offer more complete coverage, or an otherwise more desirable plan in its area, they will have an incentive to improve the local plan. Sub-

[16] Moreover, in Lane County there has been the exceptional existence of two medical society sponsored prepaid medical care plans (Gov. Ex. 1391, R. 4981; R. 1464), which presumably compete with each other.

scribers able to make a choice between competing plans obviously have an advantage over those who must take or leave the plan offered by any organization having a monopoly of prepaid medical care in an area. Thus appellees have sought to deny subscribers any choice of plans not only by driving hospital associations from the field but also by preventing competition among medical society-sponsored plans.

(2) *Restrictions on coverage and services.*—The policy of non-competition has had further restrictive effects as a result of appellees' limiting the income level of subscribers to, and the services provided under, medical society sponsored plans. During the period of this conspiracy, the medical societies consistently have insisted that prepaid medical care be limited to low income groups (*supra*, pp. 85–8). Although the income levels under medical society approved plans have risen over the years, the organized profession never has attempted to make prepaid medical care available to all who wish to purchase it. The hospital associations, on the other hand, generally impose no income limitations (*supra*, p. 89).

Despite an apparent widespread demand for extension of prepaid medical care coverage from the wage earner to the entire family, the state and several of the county societies for a long time joined in flatly opposing such a broadening

of medical care benefits (*supra*, pp. 89–90). OPS offered no family contract until 1946; even today it must obtain permission of the local medical society before writing family coverage in any area (*supra*, p. 90).

Another instance of appellees' restrictive practices was their consistent endeavor to insure that the Oregon Blue Cross hospitalization organization provide only hospitalization and not medical service and that medical society sponsored plans provide only medical service and not hospitalization (*supra*, pp. 90–1). Similarly, they have opposed the inclusion of chiropractic and osteopathic services in medical society sponsored plans (*supra*, p. 91).[17] Finally, since 1939, the State Society has disapproved the furnishing of drugs and medical supplies under such plans (*supra*, p. 92).

In summary, appellees' restrictive practices meant that subscribers received less under their medical care policies than would have been available to them under a competitive system responsive to the demands of the population.

3. APPELLEES HAVE RESTRAINED THE PREPAID MEDICAL-CARE BUSINESS IN OREGON

Contrary to Finding 33 (R. 2024), the result of appellees' activities has been to restrain the prepaid medical-care business in a number of ways.

[17] The unavailability of chiropractors led one employee group to shift from OPS to hospital association coverage. See *supra*, pp. 91–2.

The business of the hospital associations has been adversely affected by the widespread refusal of Oregon doctors to deal with them. One organization, the Pumphrey Company, was forced out of business due to inability to obtain doctors to service its accounts; another, the Weston Company, went out of the prepaid medical-care business after two of its staff doctors had resigned under the pressure of disciplinary proceedings (supra, pp. 49–50. A substantial number of accounts was lost by the other hospital associations to medical society sponsored plans (*supra*, p. 68); it is impossible to conjecture how much new business went to OPS instead of to the hospital associations because of the boycott.[18] Many industrial firms were, as a practical matter, forced to give up dealing with the hospital associations they favored to avoid the hardships of the boycott. Employers, employees, and hospital associations were subjected to needless work and annoyance. Members of the Eagles lost the benefits of medical services previously enjoyed. The people in the McMinnville area were denied the opportunity to organ-

[18] There is no record support for the statement in Finding 32 (R. 2024) that no conduct of appellees has prevented or hindered prepaid medical care organizations from expanding their business in Oregon. The evidence is to the contrary. In fact, the sales manager of Industrial's individual department found it so difficult to get accounts because of the boycott that he quit his job (R. 699–702).

ize their own cooperative health plan (*supra*, pp. 80–1). Oregon subscribers were denied the advantages of competition between medical society sponsored plans. In summary, appellees used the monopoly power of the medical society to "gain a competitive advantage" over and, in some instances, to "destroy a competitor"—the hospital associations. Such a use of that power, "however lawfully acquired * * * is unlawful." *United States* v. *Griffith*, 334 U. S. 100, 107.

Under these circumstances, appellees cannot be heard to say that they did not intend to restrain the prepaid medical care business. Their own pronouncements make it abundantly clear that they did. But even the absence of such a specific intent would not exculpate them. The Sherman Act is violated if, as a natural consequence of the acts committed, trade is in fact restrained. *United States* v. *Griffith*, 334 U. S. 100, 105; see *United States* v. *Columbia Steel Co.*, 334 U. S. 495, 525; cf. *United States* v. *National City Lines*, 186 F. 2d 562, 571 (C. A. 7), certiorari denied, 341 U. S. 916. Here the causal chain is clear and unbroken.

4. APPELLEES HAVE SOUGHT TO MONOPOLIZE THE PREPAID MEDICAL CARE BUSINESS IN OREGON

It is a violation of Section 2 of the Act to combine, conspire or attempt "to acquire or maintain the power to exclude competitors from any part

of the trade or commerce among the several states or with foreign nations, provided they also have such a power that they are able, as a group, to exclude actual or potential competition from the field and provided that they have the intent and purpose to exercise the power." *American Tobacco Co.* v. *United States,* 328 U. S. 781, 809. The district judge's finding that appellees' motive was not to monopolize, (Fdg. 37, R. 2025–2026), is unsupported by anything in the record beyond appellees' unsubstantiated testimony that they did did not intend to monopolize. The evidence is clearly to the contrary.

The intent to exclude all competing prepaid medical care plans is shown by appellees' explicit pronouncements and by their program designed to achieve that end. On at least three separate occasions, the State Society made clear its position that elimination of the hospital associations was the end in view. It spoke in terms of their being "driven from the field" (*supra,* p. 26), of "a clean sweep" being made of them (*supra,* p. 36), and of the development by the State Society of a medical care plan "to replace the existing schemes of lay hospital associations and group of physicians" (*supra,* p. 36). Furthermore, the State Society's policy that it would not "approve the plan of any hospital association that is not owned or controlled by" members of

the State and the local Society (*supra,* p. 37), coupled with the program of disciplinary action against doctors unwilling to discontinue hospital association practice, inevitably would lead to a prepaid medical care monopoly by the organized profession.

The existence of appellees' power to exclude competitors is seen in the following statistics: In 1948 and 1949, approximately 75% of all doctors practicing in Oregon were members of the State Society (*supra,* p. 12). OPS, upon its organization in 1941, quickly achieved a position of pre-eminence among the prepaid medical care plans in the State. By 1943, its affiliated physicians comprised 85% of Oregon doctors, and since 1946, this number has exceeded 90% (*supra,* pp. 17–18).[19] The number of subscribers has increased almost sevenfold, from 17,600 on June 30, 1943, to 117,241 on June 30, 1949 (*supra,* p. 19). OPS' gross income increased four and one-half times from $800,200 in 1942–43, the first year of operation, to $3,602,271 in 1948 (*supra,* p. 20). OPS' 1948 gross income of $3,602,271 was more than twice that of any of its competitors. Since 1943 the medical society sponsored plans have covered approximately two-thirds of all patients under prepaid medical care in Oregon.[20]

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[19] See note 16, *supra,* p. 18, as to the apparent disparity between the figures above given relating to membership in the medical societies and affiliation with OPS.

[20] Appellees estimated that in June 1943, the medical so-

In Note 2 (R. 2009), the district judge, under the heading "This is not monopoly," referred to the fact that "only 120,000 out of 1,510,000 people in the state belong to OPS." The charge, however, is not monopolization or attempt to monopolize the Oregon population, but monopolization and attempt to monopolize the state's prepaid medical care business. The extent of appelees' control over the latter parallels the economic power possessed by the "Big Three" tobacco companies whose conviction under Section 2 of the Sherman Act was sustained in *American Tobacco Co.* v. *United States,* 328 U. S. 781. There, the percentage of total United States small cigarette production controlled by the "Big Three" was 73.3, 71 and 68%, respectively, for the significant years.

Not only have appellees obtained monopoly power in the Oregon medical care business, but such power has been acquired and maintained by practices which themselves constitute unreasonable restraints of trade. While precise data are not available, the conclusion is inescapable on this record that OPS' monopoly position has, to a considerable extent, resulted from the boycott and the lack of competition among the doctor plans. This factor itself makes such position "vulner-

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ciety sponsored plans covered about 105,000 of the 150,000 people having prepaid medical care. At the time of the trial this figure had become 200,000 out of a total of 350,000 subscribers (*supra*, p. 20).

able in a suit by the United States under the Sherman Act." *United States* v. *Paramount Pictures*, 334 U. S. 131, 171.

Although actual exclusion of competitors is not required to establish monopolization if the power to exclude exists (*American Tobacco Co.* v. *United States*, 328 U. S. 781, 809), here there was such exclusion. The uncontradicted evidence shows that at least one and probably two hospital associations, the Pumphrey and the Weston Companies, were driven out of the prepaid medical care business as a direct result of the boycott (*supra*, pp. 49–50). A clearer misuse of the monopoly power would be difficult to find.

5. THE CONSPIRACY HAS NOT BEEN ABANDONED

The district judge found that even if there had been a conspiracy prior to 1941, it had been terminated either as a result of the organization of OPS (Fdg. 39, R. 2026), or of the entry of "a large percentage of Oregondoctors * * * [into] the armed forces in the period 1941–1945" (Fdg. 38, R. 2026). Both of these findings are without support in the record and are clearly contrary to the evidence.

Initially, it should be noted that abandonment of a conspiracy will not be presumed, but requires "definite proof to that effect." *Local 167* v. *United States*, 291 U. S. 293, 298; *Hyde* v. *United States*, 225 U. S. 347, 369; cf. *Hartford-Empire Co.* v. *United States*, 323 U. S. 386, 399. Here

not only did appellees fail to offer proof of specific acts of abandonment, but "The Government introduced substantial evidence which uncontradicted and unexplained tends to show the conspiracy and appellants' participation continued until the filing of the * * * complaint." *Local 167* v. *United States, supra.*

Organization of OPS did not end appellees' campaign against the hospital associations. On the contrary, it continued with its customary vigor. In fact, OPS gave the doctors a new advantage, since the boycott could be coupled with the offer of coverage under the doctors' own plan. The relationship between a State-wide doctor plan—contemplated as far back as 1938—and the boycott hardly could have been unanticipated when OPS was organized. Indeed, there is evidence that the organization of OPS dissipated any reluctance that doctors may have had in joining the boycott. (Gov. Ex. 611, R 3643, *supra,* p. 60.) Even if OPS was "an entirely legal and legitimate effort by the profession to meet the demands of the times for broadened medical and hospital service" (as the district judge concluded, R. 2006–7), that does not indicate that its organization marked the termination of the conspiracy. "Even an otherwise lawful device may be used as a weapon in restraint of trade or in an effort to monopolize a part of trade or commerce." *Schine Chain Theatres* v. *United States,* 334 U. S. 110, 119.

At no time have appellees repudiated the boycott or urged the profession to terminate it.[21] Attacks on hospital association and other contract practice have continued. Contract practice was vigorously condemned in 1944 and 1945 (*supra*, pp. 77–8). Doctors were told in 1946 that when seeing contract cases as private patients they were under "no obligation whatever" to "make any kind of a report" on the patient's condition to a third party (*supra*, p. 57). Particularly significant in this connection is the fact that many members of the medical profession believed in 1947 and 1948 that the medical society policy prohibited any dealings with hospital associations; many of them specifically referred to such policy in returning hospital association checks in those years (*supra*, pp. 60, 65–7).[22] Furthermore, appellees admit that the intentional absence of competition between OPS and the the other doctor plans has continued to the present time.

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[21] The action of the Jackson County Society in 1940, *supra*, p. 65 (Gov. Ex. 1751, R. 5339), is a formal, though not real, exception to the above statement. However, in some counties the formal date for *inauguration* of the boycott was not until 1942.

[22] This attitude is hardly consistent with the conclusion in Finding 36 (R. 2025) that "the past is gradually becoming forgotten." Note also, in this connection, that in 1947, a bill was introduced in the Oregon legislature, allegedly under the sponsorship of the general manager of National Hospital Association, to outlaw many of the practices engaged in by appellees during the conspiracy. The bill was not passed. Gov. Ex. 2090, R. 6421.

Contrary to Judge McColloch's finding (Fdg. 38, R. 2026), that the conspiracy was terminated during the period 1941 to 1945 when "a large percentage of Oregon doctors" were in the armed forces,[23] the record shows that it continued unabated during those years. In fact, doctors returning from service in 1945 and 1946 were informed that the campaign was still extant. Doctors "recently returned from service" were advised in 1946 to see patients covered by hospital associations and industrial plans as private patients. See also note 96, *supra*, p. 114. The hospital associations and other non-doctor approved plans were described as "cats and dogs" (*supra*, p. 56). These tactics apparently were effective, for Dr. Parcher, a young physician recently returned from service who had affiliated with OPS, refused in the spring of 1946 or 1947 to take a National ticket, although at that time he had no personal experience with hospital associations (*supra*, p. 57). On the other hand, Dr. Ullman, who had been associated with OPS prior to going into service, could not resume his affiliation upon return to civil life when it was discovered that he was connected with the Permanente Foundation (*supra*, p. 81).

[23] Although there are references in the record to Oregon physicians being in service, there is nothing to support the finding that such group constituted "a large percentage" of the State's doctors. This issue was not the subject of any evidence or argument at the trial, and represents no more than unsupported conjecture by Judge McColloch.

The record shows numerous instances of specific restraints of the prepaid medical care business that occurred after 1945. Attempts to form a cooperative health plan in the McMinnville area in 1947 were aborted by the doctors' opposition (*supra*, pp. 80–1). Many of the accounts that shifted from hospital association coverage to OPS because of the boycott did so in 1946 and 1947 (*supra*, pp. 67–8). Clearly, this conspiracy has not been abandoned.[24]

II

Principles of Medical Ethics afford appellees no defense

Appellees, in denying that they conspired to restrain and monopolize the business of supplying prepaid medical care, contend that they acted solely in an endeavor to make the practices of the medical profession in Oregon conform to the

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[24] In appellees' incomplete brief, filed with the court below in November 1950, and constituting a part of the record in the case on file with the Clerk of this Court, the following statement is made concerning fraternal organization practice (p. 78, italics added):

"For reasons familiar to lawyers as well as to doctors, this box-top, something-for-nothing method of dispensing professional services is contrary to the code of ethics of the medical profession * * * The doctors of Oregon maintain that they have the right to enforce this ethical principle by methods such as the evidence in this case shows they have utilized. *They will continue to do so unless the Court tells them they are in error.*"

That is hardly the language of abandonment.

Principles of Medical Ethics promulgated by the American Medical Association and adopted by the appellee medical societies. Their argument is that since the Principles of Medical Ethics condemned contract practice as it was then conducted in Oregon, and that since the appellee medical societies and their membership were required by their constitutions and by-laws to conform to such Principles, they were fully justified in taking all steps necessary to eliminate such violations. Stated differently, their contention is that the restraints here imposed were not unreasonable, but were proper methods of effecting compliance with professional standards.

The District Judge apparently accepted these contentions. He found that prior to 1941 some of the appellees advised doctors not to cooperate with commercial prepaid medical organizations in certain of their practices,[25] but that such action was not the result of any conspiracy to restrain or monopolize the medical care business but was "for the purpose of maintaining the standards of medical practice" (Fdg. 22, R. 2021). He also found that prior to 1941 appellee Multnomah County Medical Society had expelled certain members associated with certain types of contract practice and threatened to expel others, but that such

[25] Compare this finding with Finding 21 (e) (R. 2021) that there has been no conspiracy or concert of action among appellees "to prevent doctors from cooperating in prepaid medical care plans not sponsored or approved" by appellees.

action was not the result of any conspiracy but was "for the purpose of maintaining and advancing the standards of medical practice" among the members of the society (Fdg. 23, R. 2022). In Conclusion of Law I (R. 2030), he stated that "Medical societies have the right to take such steps as to them shall be deemed appropriate for the purpose of upholding the standards of the medical profession," and that the "exercise of this right" was the "purpose and motive" of appellees' actions. He further found generally that any restraint of trade imposed by appellees has not been unreasonable (Fdg. 43, R. 2026–2027).

Although the Government contends that appellees' constant reference to ethical standards was but camouflage to conceal their fundamentally economic concern with the hospital associations (see *infra*, pp. 157–60), even complete acceptance of appellees' argument would not justify their position. For no matter how sincere their desire to improve the ethical standards of the medical profession, such motives would not sanction the illegal means used to achieve that end. Whatever the right of doctors to use "the sober and more kindly weapons of legitimate persuasion and reasoned argument" to convince their colleagues not to do contract work for the hospital associations and other "disapproved" groups (cf. *United States* v. *American Medical Association*, 110 F. 2d 703, 712 (C. A. D. C.), certiorari

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denied, 310 U. S. 644)—a right whose existence is extremely doubtful (*Duplex Printing Press Co. v. Deering*, 254 U. S. 443, 467)—certainly they had no right to resort to coercion and intimidation to achieve that end.

The hospital associations were organized and operating under the Oregon hospital association law, a statute that specifically authorizes the conduct of this business.[26] They were subject to the supervision of the state Commissioner of Insurance. No charge is made that they were operating illegally; even had they been so, the proper procedure would have been for appellees to bring the matter to the attention of the appropriate authorities. Cf. *Kiefer-Stewart Co. v. Joseph Seagram & Sons., Inc.*, 340 U. S. 211, 214. Illegal conduct by competitors does not justify violations of the Sherman Act. *Ibid.* Appellees had not been appointed by the state authorities as law enforcement agencies to police the medical profession and eliminate all practices of which they did not approve.

In the *AMA* case, the defendants also argued that what was done involved no more "than a reasonable regulation of the practice of medicine." *American Medical Association v. United States*, 130 F. 2d 233, 244 (C. A. D. C.). Since the validity of the defense was not specifically con-

[26] Oregon Compiled Laws Annotated (1940), § 101-901, *et seq.*

sidered by this Court under its limited grant of certiorari in that case, see 317 U. S. 519, at pp. 527–528, 317 U. S. 613, the decision of the Court of Appeals in rejecting this contention is particularly pertinent. The Court stated (pp. 247–248):

> In some instances professional groups have been charged by legislative fiat with powers and duties concerning professional education, licensure, discipline, removal of licensees from practice, and other related subjects. In such cases they act as agencies of government. Although some similar delegations of power have been made to the organized medical profession there is no evidence of delegation of power to appellants, sufficient to authorize the conduct for which they have been convicted. In the absence thereof professional groups must abide by the general laws just as scrupulously as any private citizen or private corporation. It is in this setting that appellants were permitted to organize, to establish standards of professional conduct, to effect agreements for *self-discipline and control*. There is a very real difference between the use of such self-disciplines and an effort upon the part of such associations to destroy competing professional or business groups or organizations. [Footnotes omitted.]

Reference to a "Code of Ethics" as justification for conduct violative of the Sherman Act is not novel. In *Sugar Institute* v. *United*

States, 297 U. S. 553, the members of the Institute, a trade association, had promulgated a "Code of Ethics" comprising a comprehensive set of trade practices for the sugar industry, pursuant to which prices were fixed and price competition eliminated. The members of the Institute sought to justify their conduct by reference to the chaotic conditions in the industry which the Code had endeavored to alleviate. In rejecting this argument, the Court pointed out (297 U. S. at 599):

> The freedom of concerted action to improve conditions has an obvious limitation. The end does not justify illegal means. The endeavor to put a stop to illicit practices must not itself become illicit. As the statute draws the line at unreasonable restraints, a cooperative endeavor which transgresses that line cannot justify itself by pointing to evils afflicting the industry or to a laudable purpose to remove them.

Similarly, in *United States* v. *National Association of Real Estate Boards,* 339 U. S. 485, the Washington Real Estate Board attempted to support its schedule of fixed fees by reference to its "code of ethics." The Court, in rejecting this contention summarily, stated (p. 489):

> Price-fixing is *per se* an unreasonable restraint of trade. It is not for the courts to determine whether in particular settings price-fixing serves an honorable or worthy end.

These decisions are merely two in a long line of cases in which this Court consistently has held that benevolent motives do not sanction conduct otherwise violative of the Sherman Act. *United States* v. *United States Gypsum Co.*, 340 U. S. 76; *Fashion Originators' Guild of America, Inc.* v. *Federal Trade Commission*, 312 U. S. 457; *Standard Sanitary Mfg. Co.* v. *United States*, 226 U. S. 20. The defense frequently is made in Sherman Act proceedings, but to accept it would permit "private parties to act as self-constituted censors of business ethics, to install themselves as judges and guardians of the public welfare, and to enforce by drastic and restrictive measures their conceptions thus formed." *Federal Trade Commission* v. *Wallace*, 75 F. 2d 733, 737 (C. A. 8).

The fact that appellees are a professional group, and that their attempted justification is predicated upon maintenance of professional rather than business ethics, is immaterial. The so-called professional ethics, insofar as they pertain to contract practice in this case, are a set of business standards applied to the economic aspects of the medical profession. Thus, among the conditions listed by the Principles of Medical Ethics (R. 2057) under which contract practice may be "unethical" is "when there is interference with reasonable competition in a community."[27] By appellees' own

[27] Similarly, disposal by a doctor of his services "under conditions which interfere with reasonable competition among the physicians of a community" is "unprofessional" (Gov. Ex. 2, R. 2057, portion not printed).

precepts, ethical standards wear the dollar sign. The situation is that of a trade association which undertakes to eliminate price-cutting competitors by a campaign of boycott and pressure. Cf. *Fashion Originators' Guild of America, Inc.* v. *Federal Trade Commission*, 312 U. S. 457.

Although appellees couched their attacks on contract practice in terms of "unethical" professional conduct, their own pronouncements—rejected by Judge McColloch in favor of their self-serving disclaimers of evil intent—make it abundently clear that their major concern was with the economic effects on their own practices of the competing hospital associations and other forms of contract practice.[28] The Multnomah Industrial Health Association had been organized in 1932 with the hope that a "physician-owned organization * * * could attract much of the work which was then going to the then organized hospital associations" (*supra*, p. 25). The violations of the Principles of Medical Ethics that led to the subsequent repudiation and condemnation of the Association by the Multnomah County society involved such matters as: (1) the plan had extended its coverage to school teachers earning more than $1,500 a year and, "in order to

[28] Many of appellees' own doctor witnesses, testifying as to why they had given up hospital association work, referred to the fact that the associations paid inadequate fees or reduced the fees in the bills initially submitted by them (e. g., R. 1002–4, 1089–91).

meet the competition of other like organizations," to certain executives earning more than $1,800 annually; (2) under the plan many doctors had had to care for their "former pay patients" at the "low net fees" paid by the Association; (3) the operations of the plan had "resulted in a decreased income from patients who are able to pay customary fees and in the loss of some of these patients by doctors outside the Association. * * * The coverage of this group of persons by the Association has deprived their family physicians of a source of income to which the latter are entitled and were receiving until the advent of the Association." Perhaps the most serious violation arose out of the fact that the plan had had "no appreciable effect on the proprietary hospital associations," since its subscribers had been "largely drawn from groups of persons who have never before been brought under a scheme of contract medicine" (*supra*, pp. 26, 28).

During 1936, the State Society frequently voiced its concern with the economic aspects of medicine. It pointed out to the profession that the attitude of the county societies toward "unfair economic practice" was a matter of concern to county, state and national orga izations (Gov. Ex. 272, R. 2782), and that the activities of the hospital associations had been one of the causes "leading to the impoverishment of the physician" during

the depression (*supra*, p. 31). The society objected to "increasing solicitation" by the associations "of a new class of business in towns and cities where medical service was readily available to all under the usual conditions of private practice" (*supra*, p. 31). This latter frank admission indicates that the society's real objection was not to solicitation *per se*, but to solicitation of patients by the associations away from private practice to prepaid medical care.

In subsequent years, appellees' own statements and actions leave no room for doubt that it was the economic threat of the commercial associations to the doctors' fee practice that was the root of their hostility. When the final report of the State Society's medical care committee concluded that some plan of prepaid medical care for the low wage group was "here to stay" (Gov. Ex. 2085, R. 6414), the profession organized in its own statewide plan, Oregon Physicians Service, with limitations on income level of subscribers and services and coverage (*supra*, pp. 85–92).

In all the State Society's studies of low cost medical care, the importance of limiting the income level of subscribers was emphasized (*supra*, p. 85–8), and the county societies, in organizing their own plans, frequently sought advice from the State Society on appropriate limitations (*supra*, p. 88).

During the campaign against railroad and contract practice in 1944 and 1945, doctors engaged

in the former had to be enlightened "as to the economic facts * * * involved." It was pointed out that if railroad employees could be induced to obtain medical care on a private patient basis from their personal physicians, it would "probably not be at the same cut-rate cost heretofore enjoyed by railroads and railroad employees at the expense of the medical profession" (*supra*, p. 77). Doctors were advised in 1945 that "there should be no occasion" for them to depart from the policy of seeing contract cases as private patients "in their own professional and financial interest" (*supra*, p. 78). An attack in 1945 on a telephone employees' prepaid medical care plan described it as "a bold attempt to foist cut-rate medicine" upon doctors and their patients; doctors participating in the plan were condemned in 1947 for "selling both themselves and their colleagues down the river of cut-rate medicine to ultimate disaster" (*supra*, p. 79).

The reasons given by appellees for attacking the hospital associations must be examined in the light of the foregoing. Appellees' principal complaints against the associations were solicitation, lay interference in the doctor-patient relationship, and limitations on the number of doctors available to participants. The validity of the solicitation objection must be considered in the light of the fact that the very thing to which appellees objected in 1936 is now being done by their own organization, OPS (*supra*, p. 19)—although

the Principles proclaim that "Solicitation of patients by physicians as individuals, or collectively in groups—or by institutions or organizations—is unprofessional" (Gov. Ex. 2, R. 2057, portion not printed).

The claim of lay interference rested on the fact that it was necessary for the doctors to get clearance from the associations before undertaking major surgery or extensive treatment. The clearance merely indicated the association's willingness to pay for the service.[29] The same kind of clearance is required under the doctors' own plans, and would appear necessary in all plans of this type to avoid undue dissipation of funds.[30] Clearly the objection was not based on the fact that the hospital associations had nondoctor stockholders, because even the proposed elimination of such stockholder by Industrial, in an effort to placate medical society opposition, did not remove appellees' condemnation (*supra*, p. 38).

For a time, some of the commercial associations did limit their panels of doctors in certain areas. However, closed panels had been completely eliminated by 1940 (*supra*, p. 21), and thereafter any restriction on the public's free choice of physicians resulted from the conspiracy rather than

[29] In determining whether it would pay for a particular treatment, the association had the consultative aid of its own medical staff.

[30] Brown, *American Experimentation in Meeting Medical Needs by Voluntary Action*, 6 Law and Contemporary Problems 507, 515.

any policy of the associations. Thus OPS subscribers have been denied the services of doctors who, because of expulsion from the medical society for hospital association affiliation, were ineligible for OPS participation (*supra*, p. 17, n. 15). Realistically, moreover, there is no such thing as an absolute free choice of physicians. An individual's ability to select his doctor often is restricted by his financial situation. While group practice restricts the public to members of the particular group, it would seem that members of the public exercise their free choice of physicians whenever they select a particular medical-care plan—and the group of physicians that goes with the plan—with full knowledge of its capabilities and limitations.

A case strikingly similar to the case at bar is *Pratt* v. *British Medical Association* [1919] 1 K. B. 244. Plaintiff doctors had been expelled from the medical society for joining, in violation of the society's so-called ethical rules (p. 269), the Coventry Provident Dispensary which provided low-cost medical care and engaged in "contract practice," and they had been subjected to an organized boycott by the profession. In a tort action for conspiring to injure the plaintiffs in the practice of their profession, the defendants sought to justify their conduct on the ground that they had acted "with the legitimate object of advancing their professional interests" (p. 265). The court, in rejecting this defense, pointed out that the defendants sought "to enforce, by boy-

cott and by the infliction of ruin, their own standard of medical honour and interest throughout the country" (p. 269). At p. 272 the court said:

> Now, what had the plaintiffs in fact done? They had merely accepted posts as the medical officers of a highly respectable and well-managed dispensary upon terms which gave them ample remuneration, adequate leisure, and a full opportunity of private practice and a right to claim and exert all the honourable requirements of professional men. Their only fault lay in the fact that their acceptance of the posts prevented the local medical men from achieving their wish either to capture or to destroy the Coventry Dispensary. The alleged sin was financial rather than moral in its character * * * The pecunary interests of the Coventry doctors lay at the root of the matter. The question of ethics, as that word is ordinarily understood, had nothing to do with the case. * * * If the Coventry Dispensary had been destroyed as a lay organization, then the local doctors could obviously have taken such steps as would have increased their area of private practice, and their emoluments would have gained a corresponding expansion."[30a]

Similarly, had the conspiracy succeeded fully in the instant case, the resulting elimination of the

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[30a] The critical comments on the *Pratt* case in *Ware and DeFreville, Ltd.* v. *Motor Trade Ass'n*, [1921] 3 K. B. 40, do not overrule or disapprove its basic doctrine.

hospital associations and monopolization of the prepaid medical care business by medical society sponsored plans would have enhanced substantially the practices and incomes of the antiassociation doctors.

The reasonableness of a restraint of trade "must be judged in part at least in the light of its effect on competition * * *" *United States* v. *Trenton Potteries Co.*, 273 U. S. 392, 397. Although many Oregon doctors apparently were satisfied with the financial and other conditions of hospital association and other contract practice, appellees assumed the power to decide whether doctors could continue such work. To implement their negative decision, appellees resorted to every means at their disposal, including exercise of their coercive power over doctors. Their stated motive was ethical, their actual reason economic. The resulting restraints limited the rights of Oregon patients to purchase, and of Oregon doctors to sell their professional services on terms of their own choosing. Such restraints clearly were unreasonable if not unlawful *per se*. See, *e. g.*, *supra*, p. 136.

III

The business of supplying prepaid medical care constitutes "trade" or "commerce" under the Sherman Act and the commerce clause of the Constitution

A. Although the district judge did not make any formal findings with respect to whether the sale of prepaid medical care by the hospital associations constitutes trade or commerce within

the Sherman Act, he must be deemed to have so found, in view of the statement in that portion of the opinion captioned "Findings on Subsidiary Issues" that "the privately owned hospital associations * * * are engaged in a trade" (R. 2008).[31] However, the district court did specifically find that "The sale of medical services, by doctor sponsored organizations[32] * * * is not trade or commerce within the meaning of Section 1 of the Sherman Antitrust Law, nor * * * commerce" within the commerce clause of the constitution (Fdg. 42, R. 2026).[33]

We submit that this "finding," as well as the court's failure to make a specific affirmative find-

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[31] This view is substantiated by the district judge's action in changing the words "The sale of medical services, whether by a plan of prepaid medical care or otherwise" in Finding 42 as submitted by appellees (R. 2042), to read (R. 2026) "The sale of medical services, *by doctor sponsored organizations* * * * is not trade * * *" (italics supplied).

[32] Since two of the hospital associations are "doctor sponsored," *i. e.*, all of their stockholders for many years have been doctors, the phrase "doctor sponsored organizations," as used by the district judge, must be taken to mean medical society approved plans.

[33] This finding appears inconsistent with the court's finding that OPS and the other doctor sponsored plans "are business competitors with the privately-owned profit making organizations operating in the State of Oregon" (Fdg. 40, R. 2026; cf. Fdg. 39), and with the reference to "the business of prepaid medical care" in Finding 37 (R. 2025–26). Moreover, the business of even the doctor sponsored plans is not limited to the *sale* of medical services, but also involves many other commercial activities in connection with their rendition.

ing with respect to the hospital associations, are clearly erroneous, since the uncontroverted evidence demonstrates that both the medical society sponsored organizations and the hospital associations are engaged in trade and commerce. As the complaint charged and the proof showed, they are engaged in "the business of selling and furnishing prepaid medical care."

The Oregon prepaid medical care plans, both commercial and medical society sponsored, deal with the financial aspects of a medical care program. They sell medical care policies, make contractual arrangements with the participating physicians and hospitals, bill and collect from the subscribers, make periodic payments to the doctors and hospitals for services rendered, adjust financial differences with the physicians, and procure and distribute necessary drugs and medical supplies. They pursue an aggressive sales promotion campaign through press, radio and personal contact, employing a staff of salesmen and expending a substantial advertising budget. The services they have supplied include not only medical treatment, but also hospitalization, drugs and medicines, and dental and nursing care (*supra*, pp. 17, 21). From the viewpoint of the patient, these organizations take care of the *business* end of his medical problems. His principal financial dealings are with them, and his relationship with the doctor is concerned almost entirely with the professional—*i. e.* treatment—aspects of medicine.

In a similar situation, this Court held in *American Medical Association* v. *United States,* 317 U. S. 519, that Group Health Association, a cooperative prepaid medical organization in the District of Columbia, was "engaged in business or trade." In return for a fixed monthly payment, Group Health rendered comprehensive medical care as needed. The association maintained a clinic, employed a staff of doctors and medical technicians, and provided hospitalization for its members. The defendants, the American Medical Association and the District of Columbia Medical Association, were convicted of conspiring to restrain the trade or commerce of Group Health in violation of Section 3 of the Sherman Act. On appeal, they contended in this Court that their activities were not within the Act, arguing that the practice of medicine was not a trade. The court found it unnecessary to reach this question, however, in view of its conclusion that Group Health itself was engaged in trade. The Court stated (pp. 528–9):

> Group Health is a membership corporation engaged in business or trade. Its corporate activity is the consummation of the cooperative efforts of its members to obtain for themselves and their families medical service and hospitalization on a risk-sharing prepayment basis. The corporation collects its funds from members. With these funds physicians are employed

> and hospitalization procured on behalf of members and their dependents. The fact that it is cooperative, and procures service and facilities on behalf of its members only, does not remove its activities from the sphere of business.
>
> * * * As the Court of Appeals properly remarked, the calling or occupation of the individual physicians charged as defendants is immaterial if the purpose and effect of their conspiracy was such obstruction and restraint of the business of Group Health. The court said: "And, of course, the fact that defendants are physicians and medical organizations is of no significance, for Sec. 3 prohibits 'any person' from imposing the prescribed restraints * * *." It is urged that this was said before this Court decided *Apex Hoisery Co.* v. *Leader,* 310 U. S. 469. But nothing in that decision contradicts the proposition stated. Whether the conspiracy was aimed at restraining or destroying competition, or had as its purpose a restraint of the free availability of medical or hospital services in the market, the *Apex* case places it within the scope of the statute. [Citations omitted.]

There are no significant differences between the activities of Group Health that were held to constitute trade or commerce in the *AMA* case, and the activities of the prepaid medical plans

involved in the instant proceeding.[34] Both types of organizations are engaged in providing "medical service and hospitalization on a risk-sharing prepayment basis." In each instance they use the funds collected from their participants as the source of payments to physicians and hospitals. It is immaterial that the Group Health doctors were staff members on a salary, whereas under the Oregon plans the doctors generally maintain their own independent practices and receive payment for services rendered to participating patients. The significant factor is the kind of activity engaged in, not the internal organization utilized for its conduct.

Nor is there any basis for the distinction, apparently drawn by the district judge, between the hospital associations and the medical society sponsored plans. Both are in the prepaid medical care market place, selling and servicing medical care policies.[35] The fact that most of the medical society plans are nonprofit[36] is immaterial, since nonprofit as well as profit organizations may be

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[34] In fact, the hospital associations would appear to present an even stronger case than Group Health, since they are profit organizations. And, although the former are largely doctor owned, such doctor-owners are not selling their own services through the plans.

[35] Both types of plans are regulated by the Oregon Commissioner of Insurance.

[36] Some of the local medical society sponsored plans do operate at a profit (Def. Ex. 2762, R. 7072).

engaged in commerce. *American Medical Association* v. *United States, supra;* cf. *Associated Press* v. *National Labor Relations Board,* 301 U. S. 103, 128–129. And although OPS, like any mutual insurance company, may be nonprofit, it conducts a substantial business operation; its 1948 gross income of $3,602,271 (*supra,* p. 20) was more than twice that of any of the competing hospital associations. This reflects the substantial national growth in recent years of medical care plans sponsored by state or local medical societies which, as of January 1, 1948, were reported to be operating in more than forty states with an enrollment of 7.5 million participants. Klem & McKiever, *Program Developments and Benefit Trends in Voluntary Health Insurance,* 11 Social Security Bulletin No. 11, p. 4.

The service sold by both the commercial hospital associations and the medical society sponsored plans is the underwriting of any medical expenses that may be incurred. In fact, in certain particulars the contracts provide for payment of indemnity rather than supplying of services. Such business is similar to that of a fire insurance company in underwriting pecuniary losses caused by fire, which was held to constitute commerce under the Sherman Act in *United States* v. *South-Eastern Underwriters Association,* 322 U. S. 533. The *AMA* and *South-Eastern Underwriters* opinions, when read

together, make it clear that the basically commercial character of the activities of all the Oregon prepaid medical care plans unequivocally bring them within the Federal commerce power.

It is immaterial that these organizations are selling services rather than goods.[37] The marketing of services as well as the sale of goods comes within the trade or commerce whose restraint or monopolization the Sherman Act prohibits. *Atlantic Cleaners and Dyers, Inc.* v. *United States,* 286 U. S. 427; *Associated Press* v. *United States,* 326 U. S. 1; *United States* v. *South-Eastern Underwriters Association,* 322 U. S. 533; *United States* v. *National Association of Real Estate Boards,* 339 U. S. 485; cf. *Apex Hosiery Co.* v. *Leader,* 310 U. S. 469, 493.

In the *Real Estate Boards* case, *supra,* the Court, in holding that the business of a real estate agent did constitute "trade" within Section 3 of the Sherman Act, pointed out that "The fact that the business involves the sale of personal services rather than commodities does not take it out of the category of 'trade' within the meaning of § 3 of the Act. The Act was aimed at combinations organized and directed to control of the market by suppression of competition 'in the marketing of goods and services.' See *Apex Hosiery Co.* v. *Leader, supra,* p. 493." 339 U. S.

[37] To the extent that the plans provide drugs and medical supplies, they are selling goods.

at 490. The Court stated (p. 491) that "The fixing of prices and other unreasonable restraints have been consistently condemned in case of services as well as goods." Among the examples given of such services was "the procurement of medical and hospital services," as authority for which the Court cited the *American Medical Association* case.

The issue in this case is not whether the practice of medicine constitutes trade or commerce within the Sherman Act, but whether the *business* of furnishing prepaid medical care constitutes such commerce.[38] Appellees cannot escape the Act's thrust because they are members of a learned profession. As this Court pointed out in the *American Medical Association* case, *supra,* the ban of the Sherman Act applies to "every person" who conspires to restrain or monopolize trade or commerce. Once the fact of unreasonable restraint or of monopolization of a trade is established, the occupation of the conspirators is immaterial.[39]

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[38] Cf. *Jordan* v. *Tashiro*, 278 U. S. 123, 129, in which the word "trade" in a Japanese-American treaty was considered to cover "the operation of a hospital *as a business undertaking.*" [Italics supplied.] Also cf. *National Labor Relations Board* v. *Central Dispensary and Emergency Hospital*, 145 F. 2d 852 (C. A. D. C.), certiorari denied, 324 U. S. 847.

[39] The medical profession has described itself in commercial terms. A 1949 article in the Journal of the American Medical Association spoke of the "flow of medical trade" in connection with a medical service area map of the country. It

The Oregon prepaid medical care plans, no matter by whom sponsored, clearly are engaged in trade or commerce under the Sherman Act. To hold otherwise would be to contract the scope of the concept "restraint of trade" in the same "precedent-breaking manner" that this Court refused to do in *United States* v. *National Association of Real Estate Boards*, 339 U. S. 485, 492, in rejecting the contention that real estate agents were not in "trade" or "commerce."

B. It thus appears unnecessary for the Court to consider whether certain aspects of the practice of medicine themselves may involve a "restraint of trade" within the Sherman Act. However, if the Court disagrees with us in this respect, we submit that a proper interpretation of the Sherman Act unequivocally leads to the conclusion that the economic aspects of the medical profession do come within the statute. We wish to emphasize that the issue is not the applicability of the Sherman Act to the profes-

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pointed out that local commercial establishments have an area from which they draw their trade. "In the present study we are concerned with the purchases of the services of the physicians, not of groceries, hardware or the better grades of women's dresses. The established procedures for laying out marketing areas have been followed in this study. In particular, we are trying to show where the patients live who are served by the physicians in the towns and cities of the area. Some patients do obtain some or all of their physician services outside their own area—a feature of all trading areas" (Gov. Ex. 1674, R. 7404–5).

sions generally, but solely to certain economic and business aspects of medicine.[40]

The Sherman Act "* * * was drawn in the light of the existing practical conception of the law of restraint of trade." *Standard Oil Co.* v. *United States,* 221 U. S. 1, 59. "The common law of doctrines relating to contracts and combinations in restraint of trade were well understood long before the enactment of the Sherman law." *Apex Hosiery Co.* v. *Leader,* 310 U. S. 469, 497. As this Court said in the *Apex* case (310 U. S. at 498), when Congress passed the Sherman Act:

> the legislators found ready at their hand the common law concept of illegal restraints of trade or commerce. In enacting the Sherman law they took over that concept by condemning such restraints wherever they occur in or affect commerce between the states. They extended the condemnation of the statute to restraints effected by any combination in the form of trust or otherwise, or conspiracy, as well as by contract or agreement, having those effects on the competitive system and on purchasers and consumers of goods or serv-

[40] Thus viewed, the District Court's broad "finding" that "The practice of medicine as conducted within the State of Oregon * * * is not trade or commerce" (Fdg. 41, R. 2026) is not germane to the issues in this case.

ices which were characteristic of restraints deemed illegal at common law * * *."

Accordingly, the meaning of the phrase "restraint of trade" in the Sherman Act is not to be determined by seeking separate definitions of "restraint" and of "trade". The phrase was used by Congress as words of art, and it is the common law concept of "restraint of trade" that must provide the source of guidance. This concept had a well defined meaning at common law long before passage of the Sherman Act, and it was this body of doctrine that Congress

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[1] Cf. *United States* v. *Addyston Pipe & Steel Co.*, 85 Fed. 271 (C. A. 6), affirmed, 175 U. S. 211, where the view that the Sherman Act was to be construed with reference to the common law doctrine of restraint of trade was first enunciated. The court there stated (pp. 278–9): "* * * it is certain that, if the contract of association which bound the defendants was void and unenforceable at the common law because in restraint of trade, it is within the inhibition of the statute."

The legislative history of the Act bears out this view. Senator Hoar, a member of the Judiciary Committee, told the Senate: "We have affirmed the old doctrine of the common law in regard to all interstate and international commercial transactions." 21 Cong. Rec. 3146. Senator Edmonds, Chairman of the Committee, explained that the intent was to define the offense in "terms that were well known to the law already." 21 Cong. Rec. 3148. Later in the debate Senator Hoar stated that "The great thing that this bill does * * * is to extend the common law principles which protected fair competition in trade in old time in England, to international and interstate commerce in the United States." 21 Cong. Rec. 3152.

adopted when it employed the phrase "restraint of trade" in the legislation.[42] Authorities holding that in other contexts the practice of medicine is a profession and not a trade[43] are irrelevant to the question of whether certain activities by doctors may involve a "restraint of trade."

The concept of restraint of trade developed at common law as a means of securing and protecting the right of an individual freely to pursue his chosen calling, no matter what it might be—tradesman, craftsman, or professional.[44] It evolved out of the restrictive practices of the guilds in denying non-member individuals access to the market where they might freely dispose of their goods and services. Jones, *Historical Development of the Law of Business Competition*, 35 Yale L. J. 905, 920–930 (1926). In one of

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[42] This view is supported by the language of the Act itself. Since the statute was based on the power of Congress over interstate commerce, the "trade" referred to in Sections 1 and 2 cannot have any broader meaning than commerce. Accordingly, use by Congress of the phrase "restraint of trade" instead of "restraint of commerce" indicates an intention to adopt the common law concept connoted by these words of art.

[43] *E. g., Federal Trade Commission* v. *Raladam Co.*, 283 U. S. 643.

[44] See *Standard Oil Co.* v. *United States*, 221 U. S. 1, 51: "* * * at a very remote period the words 'contract in restraint of trade' in England came to refer to some voluntary restraint put by contract on an individual on his right to carry on his trade or calling."

the earliest and most famous cases dealing with restraint of trade, *Doctor Bonham's Case,* 8 Coke Rep. 107a, 2 Brownl. 255, decided in 1610, the court aided a qualified physician who had been denied the right to practice medicine by the arbitrary action of the Royal College of Physicians in London. Thus, almost 300 years before the passage of the Sherman Act, the right of a doctor to practice his profession was judicially protected against unfair interference.

As the law developed, absolute restraints of trade were held invalid, but partial restraints incurred in connection with the sale of a business or the employment of an apprentice were sustained if reasonable. The sale of a medical practice was a common occurrence, and the good will purchased was protected. For almost 100 years prior to the enactment of the Sherman Act the courts, both in England and America, had treated restrictive covenants by physicians as involving restraints of trade, and had tested their validity by the usual standard of reasonableness that was applied to restrictive covenants in other phases of commercial activity. In other words, a doctor was considered engaged in trade within the meaning of "restraint of trade."

In *Davis* v. *Mason,* 5 T. R. 118, 101 Eng. Reprint 69, decided in 1793, the court viewed an agreement by an assistant to a surgeon not to

practice his profession within ten miles of the town where he was employed for fourteen years after termination of his employment as a restraint of trade, but upheld it as reasonable. Subsequent English decisions [45] and early American cases decided before the enactment of the Sherman Act [46] follow this principle. In *Gilman* v. *Dwight,* 79 Mass. 356 (1859), the court, although holding that a contract limiting a doctor's right to practice was only in partial restraint of trade and therefore not unlawful, said (p. 359):

> There is nothing in the nature of the business or profession [of a doctor] to which the contract relates, which takes it out of the ordinary rules applicable to contracts in partial restraint of trade.

And in *Hill* v. *Gudgell,* 9 Ky. L. R. 436, 437 (1887), the court stated that cases "where physicians have sold their good will and agreed not to practice medicine within certain distances of their former location * * * fall within the general principle governing contracts in restraint of trade." [47]

Closely in point is the decision and reasoning in *Pratt* v. *British Medical Association,* [1919]

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[45] *Hayward* v. *Young,* 2 Chitty 407 (1818); *Atkyns* v. *Kinnier,* 4 Ex. 776 (1850).

[46] *Cook* v. *Johnson,* 47 Conn. 175 (1879); *Haldeman* v. *Simonton,* 55 Iowa 144 (1880); *Mandeville* v. *Harman,* 42 N. J. Eq. 185 (1886).

[47] Other cases are collected in 58 A. L. R. 156, and Dodd, *Contracts Not To Practice Medicine,* 23 B. U. L. Rev. 305 (1943).

1 K. B. 244, discussed *supra*, pp. 162–3. The Court, in condemning the expulsion of certain doctors from the Medical Society and their boycott by the organized profession for violation of the society's so-called 'ethical rules" in joining the staff of a dispensary engaged in contract practice, held that such rules were "in restraint of trade" and were "void" on the ground of public policy. The rules "gravely, and * * * unnecessariily, interfere with the freedom of medical men in the pursuit of their calling, and they are * * * injurious to the interests of the community at large" (p. 274).

In short, it is the character of the restraint itself and not the nature of the particular activity restrained that is controlling. The practice of every profession has many significant economic and business aspects,[48] and when the professional man enters the market place, his activities may

[48] As illustrative of this distinction, compare *San Carlo Opera Co.* v. *Conley*, 72 F. Supp. 825 (S. D. N. Y.), affirmed, 163 F. 2d 310, (C. A. 2), holding that a contract by a professional singer to sing for an opera company, in the performance of which he would have to travel interstate, did not relate to interstate commerce within the Federal Arbitration Act, with *Ring* v. *Spina*, 148 F. 2d 647 (C. A. 2), certiorari denied, 335 U. S. 813, holding that a contract relating to the readying of a musical play for Broadway presentation involved a restraint of interstate commerce within the Sherman Act. The district court in the *Conley* case distinguished the *Ring* case on this very ground, *i. e.*, that it did not involve "a contract for the individual performance of an artist" (72 F. Supp. at 831), but related to the commercial aspects of theatrical production.

affect the economy just as much as those of the tradesman or manufacturer.

A persuasive authority in support of this position is the well-reasoned opinion of the Court of Appeals on the first appeal in the *AMA* case, *United States* v. *American Medical Association*, 110 F. 2d 703 (C. A. D. C.), certiorari denied, 310 U. S. 644. The District Court has sustained a demurrer to the indictment on the ground, *inter alia*, that the practice of medicine was not a trade within the meaning of Section 3 of the Sherman Act, 28 F. Supp. 752, and the Court of Appeals reversed. The Court of Appeals, after an extensive review of the authorities, concluded that the word "trade" in the phrase "restraint of trade" covered "all occupations in which men are engaged for a livelihood."[49]

[49] Cf. *United States* v. *National Association of Real Estate Boards*, 339 U. S. 485, 491–492. The Court in its opinion in that case quoted from the opinion of Justice Story in *The Nymph*, 18 Fed. Cas. 506. The statement in that case that the concept of trade may be limited to activities "not in the liberal arts or in the learned professions" is of no significance in this context. As we have pointed out, the instant case involves not the practice of medicine, but the sale of medical services. In *The Nymph* this suggestion was pure dictum, unnecessary to the decision. The case itself involved a construction of the word "trade" in the Coasting and Fishery Act of 1793, 1 Stat. 305, a statute quite different from that in the instant case. Moreover, the reference to *The Nymph* in the *Real Estate Boards* case was solely for the purpose of indicating that the word "trade" was to be given a broad interpretation.

(110 F. 2d 710), and held that "a restraint imposed upon the lawful practice of medicine * * * is just as much in restraint of trade as if it were directed against any other occupation or employment or business" (110 F. 2d 711).[50]

There is nothing in either the legislative history or the language of the Sherman Act itself to suggest that Congress was departing from the well-known common law doctrines when it used the phrase "restraint of trade." On the contrary, the legislative history shows that Congress was fully familiar with these concepts, and intended to adopt them as the touchstone of proscribed conduct. Any blanket exemption of the professions from a regulatory statute of this kind would require a clear and express mandate from Congress. Similar attempts in the past to procure a blanket exemption of labor unions from the Sherman Act have been unequivocally rejected, and the question of applicability has been determined on a case-by-case basis.[51] The economic activities of doctors may involve "restraints of trade" just as clearly as those of real estate brokers or women's sportswear manufacturers. When organized medicine ventures into the economic arena, it must observe the same competi-

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[50] This Court found it unnecessary to consider that question in the *AMA* case because of its conclusion that Group Health Association was itself engaged in trade. 317 U. S. 519, 528.

[51] See *Apex Hosiery Co.* v. *Leader*, 310 U. S. 469, 487–493.

tive standards that are required of any other enterprise.

IV

Appellees' conspiracy to restrain and monopolize the Oregon prepaid medical care business involved and affected interstate commerce

In his opinion, the district judge assumed (without finding) that interstate commerce was "involved in this case" (R. 2007). In his conclusions of law, however, he stated that it was unnecessary, in view of his findings and conclusions, to pass upon the question whether such commerce was "involved" in the "practice of medicine" or the "sale of prepaid medical care." (Conclusion of Law IV, R. 2044). The district court also made detailed findings setting forth many of the interstate aspects of the Oregon prepaid medical care business.

The Government submits that these findings, fully supported by the record, compel the conclusion that the activities of the hospital associations and the medical society sponsored plans in the sale and servicing[52] of medical care policies involved and affected interstate commerce, and that the appellees' conspiracy was in restraint of such commerce.[53]

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[52] Not just the sale, as implied by the district court.

[53] The Government considers the question of whether the practice of medicine involved interstate commerce irrelevant to any issue in this case, since this case involves the economic aspects of a medical care program, not the practice of a profession. Accordingly, that question is not discussed.

The district court found that Oregon prepaid medical care organizations have sold prepaid medical care policies in Washington and California (Fdg. 14, R. 2019), and that industrial concerns with places of business outside of Oregon carry prepaid medical care insurance for their non-Oregon employees with Oregon medical medical care organizations (Fdg. 16, R. 2020). The record shows that the volume of such out-of-State business is substantial. National Hospital Association, for example, has accounts in "practically all the states and some of the possessions of the United States" (R. 566).[54] Industrial "covers" the States of Washington and Northern California (R. 393). The Pumphrey Company, driven out of business as a result of the conspiracy, had contracts in Washington (R. 657). Moreover, several of the organizations actively solicit such out-of-State business, sending salesmen outside Oregon to obtain new accounts (R. 357, 410, 504, 565, 609, 1899–1900). The plans also send representatives into other States to service customers there (R. 357, 504, 1899–1900).

Since the Oregon prepaid medical care organizations solicit, write and service policies in States outside of Oregon, they are themselves "doing business" in such States, and are directly engaged

[54] Approximately one-fifth of the people covered by National's contracts live outside Oregon (R. 642). In 1949, National had in effect 116 group contracts covering 4,085 employees outside the State (Gov. Ex. 1443, R. 7346; R. 496).

in interstate commerce. *Polish National Alliance* v. *National Labor Relations Board*, 322 U. S. 643; cf: *National Labor Relations Board* v. *Tri-State Casualty Ins. Co.*, 188 F. 2d 50 (C. A. 10).

The district court further found that Oregon residents covered by prepaid medical care plans are treated by out-of-state doctors and use out-of-state hospitals (Fdg. 17, R. 2020); that prepaid medical care policies issued by Oregon organizations cover reimbursement for such medical care (Fdg. 14, R. 2019–2020); that Oregon prepaid medical care organizations "arrange to pay" for such out-of-state medical care (*ibid.*); that they "use interstate transportation and transmission facilities to transmit across state lines" policies, reports, instructions and correspondence (*ibid.*); that "reports and communications" go between them and agents, doctors, and customers located outside Oregon (*ibid.*); and that medical care policies and payments thereon by policyholders have gone in interstate commerce between Oregon and other states (*ibid*).

The record shows that many industrial firms covered by Oregon prepaid medical care organizations are themselves engaged in interstate operations (R. 1689).[55] The rendering of serv-

[55] An example is Consolidated Freightways, engaged in an interstate motortrucking business. Medical care contracts of OPS with this company not only have covered Oregon personnel while outside the state but also 609 employees working in five other states (Gov. Ex. 1861, R. 157, 469). Crown-Zellerbach Company, engaged in logging operations

ice to those engaged in interstate commerce sufficiently affects that commerce to bring such service within the ambit of the Federal commerce power. Thus, intrastate utility companies have been held subject to the National Labor Relations Act because of their sales of power to concerns engaged in interstate commerce,[56] and service employees in a loft building have been held within the coverage of the Fair Labor Standards Act[57] and the National Labor Relations Act[58] because tenants in the building produced goods for interstate commerce. Similarly, the supplying of medical care to firms engaged in interstate commerce is sufficient to subject the suppliers to the Sherman Act, which, insofar as commercial restraints are concerned, exerts the full reach of the commerce power.[59]

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in Oregon and Washington (R. 694), has contracts with Industrial and National (R. 695). California-Oregon Power Company, operating in Southern Oregon and Northern California, is covered by Industrial (R. 847).

[56] *Consolidated Edison Co.* v. *NLRB*, 305 U. S. 197; *Consumers Power Co.* v. *NLRB*, 113 F. 2d 38 (C. A. 6); *Southern Colorado Power Co.* v. *NLRB*, 111 F. 2d 539 (C. A. 10); cf. *NLRB* v. *Gulf Public Service Co.*, 116 F. 2d 852 (C. A. 5).

[57] *Schulti Co.* v. *Gangi*, 328 U. S. 108; *Borden Co.* v. *Borella*, 325 U. S. 679; *Kirschbaum Co.* v. *Walling*, 316 U. S. 517.

[58] *Butler Bros.* v. *NLRB*, 134 F. 2d 981 (C. A. 7), certiorari denied, 320 U. S. 789.

[59] *United States* v. *Frankfort Distilleries*, 324 U. S. 293, 298; *United States* v. *South-Eastern Underwriters Assn.*, 322 U. S. 533, 558–9; *Apex Hosiery Co.* v. *Leader*, 310 U. S. 469, 495; *Atlantic Cleaners & Dyers* v. *United States*, 286 U. S. 427, 435.

The record also indicates that a number of employees covered by Oregon prepaid medical care plans engage in interstate travel in connection with their employment. When such employees require medical service while outside Oregon they are treated by local doctors and in local hospitals (R. 418). These doctors and hospitals are then paid by the medical care organization involved, usually after considerable preliminary correspondence (R. 418, 568). The number of such out-of-state treatments is considerable (Gov. Exs. 1443, R. 7347; 1444, R. 7354; 1445, R. 7364). Such treatments, together with the servicing of out-of-state policyholders, have resulted in extensive interstate correspondence, both to and from Oregon,[80] and a substantial volume of payments by the medical care organizations to doctors and hospitals outside Oregon (Gov. Exs. 1443, R. 7350, 7352; 1444, R. 7359, 7361; 1445, R. 7370, 7371).

During the years 1936 to May 1949, for example, National made payments to doctors in twelve states, Alaska, Canada, and the Mayo Clinic in Minnesota (Gov. Ex. 1774, not printed); such out-of-state payments constituted more than 8 percent of National's total payments to doctors (Gov. Ex. 1443, R. 7352). During the same period, approximately 6 percent of National's

[80] For the year 1948, for example, Industrial had 4½ file drawers of such correspondence (Gov. Ex. 1445, R. 7368).

total payments to hospitals went to out-of-state institutions (*ibid.*, R. 7350). From 1940 to 1948, more than 7 percent of Industrial's payments to doctors and almost that percentage of its payments to hospitals went outside Oregon; in 1948, it made payments to 257 out-of-state physicians (Gov. Ex. 1445, R. 7370–1). About 8 percent of Prudential's payments to doctors and 5 percent of its payments to hospitals went outside Oregon during the years 1943 to May 1949 (Gov. Ex. 1444, R. 7359, 7361). OPS also has made substantial payments to out-of-state doctors and hospitals (Gov. Ex. 255, R. 7215).

There is present in this case the same "continuous and indivisible stream of intercourse among the states" that led this Court to hold, in *United States* v. *South-Eastern Underwriters Association,* 322 U. S. 533, that the business of fire insurance constitutes interstate commerce. Here, as in that case, the activities of the organizations involved include not only the execution of contracts "but also negotiations and events prior to execution of the contracts and the innumerable transactions necessary to performance of the contracts" (p. 537), many of which involve the use of interstate commerce. Similarly, the decisions that the medical care organizations make at their main offices in Oregon concern not just Oregon residents but also "people living far beyond the boundaries of that state" (p. 542), including

patients, doctors, and hospitals. And, just as the insurance business was not separated into "48 distinct territorial compartments which function in isolation from each other" (p. 541), so in this case the out-of-state activities are not separated from the Oregon business, but are inseparable parts of a single integrated operation.

The significance of extensive interstate communications in bringing an enterprise within the Federal commerce power also is seen in *Polish National Alliance* v. *National Labor Relations Board*, 322 U. S. 643. In that case, this Court pointed to the "steady stream, into and out of Illinois, of bills, notices, and policies, the payments of commissions, the making of loans on policies, the insertion and circulation of advertising material in newspapers, and its dissemination over the radio" (p. 645) as evidence that the labor practices of the Polish National Alliance, a fraternal benefit society, affected interstate commerce under the National Labor Relations Act.[61] Substantially all of these aspects are present in the instant case. Here, too, there is a steady stream of doctor and hospital

[61] In *National Labor Relations Board* v. *Bank of America National Trust & Savings Ass'n*, 130 F. 2d 624 (C. A. 9), certiorari denied, 318 U. S. 791, a California bank, all but one of whose 494 branches were in California (and that one was in London), was held to be engaged in interstate commerce because of the constant flow of interstate communications, including transfers of funds. Cf. *International Textbook Co.* v. *Pigg*, 217 U. S. 91, 106–7.

bills coming into Oregon, correspondence relating to such bills going in and out of the state, payments to doctors, hospitals, and for medical services and supplies going outside Oregon, and the use of newspapers and the radio for advertising. *Supra*, pp. 19, 186–7.

The district court also found that Oregon prepaid medical care subscribers from other states come to Oregon for medical care (Fdg. 17, R. 2020). The record contains substantial evidence supporting this finding. For example, employees of a power company living in Northern California who are covered by National regularly come to Oregon for medical treatment (R. 848). Certain lumber company employees with National coverage frequently go from Washington to Oregon for treatment, although many do not because of the general knowledge that Oregon doctors do not take National tickets (R. 905–6). Patients of the Permanente Foundation are treated both in Portland, Oregon, and Vancouver, Washington, and frequently go from one state to the other to receive treatment (R. 745).[62]

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[62] The Oregon prepaid medical care organizations purchase medicines, drugs, medical supplies and instruments from out-of-state suppliers. The district court so found (Fdg. 15, R. 2020). The record shows that the volume of such purchases has been substantial. From 1941 to May 1949, National's out-of-state purchases amounted to $58,115.26 of its total purchases of $230,928.90 (Gov. Ex. 1443, R. 7349). Industrial's out-of-state purchases during the years 1940 to 1948 totaled $128,711.12 as against purchases from Oregon com-

Although the findings are silent on the point, the record indicates that several of the Oregon prepaid medical care plans furnish interstate ambulance service, both to and from Oregon (Gov. Ex. 1101, R. 7232; 1445, R. 7365; R. 465, 561–2, 905). Payments for ambulance service to out-of-state concerns constituted 6 percent of National's total ambulance service payments for the period beginning with 1936 and ending with May 1949 (Gov. Ex. 1443, R. 7351), 10 percent of Industrial's ambulance service payments for the years 1940 to 1948 (Gov. Ex. 1445, R. 7370), and 10 percent of Prudential's ambulance service payments for 1943 to 1948 (Gov. Ex. 1444, R. 7360).

The above uncontradicted evidence, and the findings of the court below show that the conduct of the medical care business "involves continuous and extensive use of the mails and instrumentalities of interstate commerce." *Electric Bond & Share Co.* v. *Securities and Exchange Commission,* 303 U. S. 419, 432–433.

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panies of $126,022.51 (Gov. Ex. 1445, R. 7366). Prudential made purchases from outside Oregon totaling $176,838.74 in the years 1936 to May 1949 (Gov. Ex. 1444, R. 7356). OPS also has made substantial out-of-state purchases of drugs and medical supplies (Gov. Ex. 254, R. 7210).

In addition to such purchases, some of the prepaid medical plans also ship first-aid supplies to subscribers outside Oregon. Thus during the years 1946 to May 1949, National shipped such supplies with a total value of $10,825.44; an average of more than 80 companies a year received such material (Gov. Ex. 1443, R. 7349).

The fact that many or most of the transactions involved in the Oregon prepaid medical care business are local in character is immaterial in determining the applicability of the Sherman Act. Acts which are themselves local are subject to the Sherman Act where they operate as a restraint upon interstate commerce. Almost all restraints occur within the borders of some state; yet it is obvious that the consequence of applying enough local restraints to an interstate business will be extinction of that business. As this Court said in *United States* v. *Women's Sportswear Mfrs. Assn.*, 336 U. S. 460, 464:

> Restraints, to be effective, do not have to be applied all along the line of movement of interstate commerce. The source of the restraint may be intrastate, as the making of a contract or combination usually is; the application of the restraint may be intrastate, as it often is; but neither matters if the necessary effect is to stifle or restrain commerce among the states. If it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze.

And see *Mandeville Island Farms, Inc.* v. *American Crystal Sugar Company*, 334 U. S. 219. In *Mabee* v. *White Plains Publishing Co.*, 327 U. S. 178, the Court applied the Fair Labor Standards Act, a statute in which Congress did not exercise fully its power over commerce (*Kirschbaum Co.* v. *Walling*, 316 U. S. 517, 523) to a newspaper

only ½ of 1% of whose circulation was out of state.[83]

Although proof of a conspiracy in restraint of interstate commerce in violation of the Sherman Act does not require any showing of actual restraints,[84] the record here shows that such commerce has in fact been burdened, restrained and, in some instances, eliminated. Not only have firms engaged in interstate commerce been burdened by being required to devote substantial time to handling administrative details and dealing with dissatisfied employees as a result of the doctors' refusal to take tickets (R. 717–719, 730–731, 791, 882, 887), but, even more important, the conspiracy here has tended to deprive employees of interstate firms either of as much coverage as they would like (see *supra*, pp. 89–92) or of the advantages of their chosen prepaid medical care plan altogether. (See *supra*, pp. 67–8.) Termination of the prepaid medical care business of the Pumphrey and Weston companies perforce resulted in cessation of all interstate phases of such business. Similarly, loss of accounts by hospital associations has eliminated the interstate commerce formerly involved in servicing such ac-

[83] The Wage and Hour Division of the Department of Labor considers both National Hospital Association and OPS to come within the general coverage of the Fair Labor Standards Act (Gov. Exs. 2195–6, R. 6606–8). In addition, Industrial Hospital Association considers itself covered by the statute (R. 1793–4).

[84] Cf. *Nash* v. *United States*, 229 U. S. 373, 378. The conspiracy, not the overt act, is the offense. *United States* v. *Socony-Vacuum Oil Co.*, 310 U. S. 150, 225, n. 59.

counts.[65] It is impossible to estimate precisely how much new business, with its interstate aspects, was denied to the associations because of the conspiracy, but there can be no question that loss of such business was a consequence.

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed and the cause remanded for entry of a decree granting appropriate relief.

Respectfully submitted.

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[65] Thus National Hospital Association had a contract with a bakery covering employees in both Oregon and California (R. 644). National lost the account as a result of the boycott (R. 644–645). In an analogous situation in *William Goldman Theatres* v. *Loew's*, 150 F. 2d 738 (C. A. 3), certiorari denied, 334 U. S. 811, a treble damage suit under the Sherman Act, the court held that a conspiracy involved interstate commerce where the effect was to prevent the plaintiffs from obtaining first-run motion picture films in Philadelphia because such films were distributed to Warner Brothers Theatres exclusively. It reached this conclusion even though the total volume of interstate commerce in first-run films moving into Philadelphia had not been diminished.

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